UNITED STATES DISTRICT COURT

IN THE DISTRICT OF IDAHO

SAINT ALPHONSUS MEDICAL CENTER - NAMPA, INC., TREASURE VALLEY HOSPITAL LIMITED PARTNERSHIP, SAINT ALPHONSUS HEALTH SYSTEM, INC., AND SAINT ALPHONSUS REGIONAL MEDICAL CENTER, INC., Plaintiffs, vs. ST. LUKE'S HEALTH SYSTEM, LTD., and ST. LUKE'S REGIONAL MEDICAL CENTER, LTD., Defendants.	Case No. 1:12-cv-00560-BLW **Bench Trial** **Opening Statements** **Witnesses:** **Jeff Thomas Crouch**
FEDERAL TRADE COMMISSION; STATE OF IDAHO, Plaintiffs, vs. ST. LUKE'S HEALTH SYSTEM, LTD.; SALTZER MEDICAL GROUP, P.A., Defendants.	Case No. 1:13-cv-00116-BLW

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REPORTER'S TRANSCRIPT OF PROCEEDINGS

before B. Lynn Winmill, Chief District Judge

Held on September 23, 2013

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PLAINTIFF FEDERAL TRADE COMMISSION

WITNESSES

* * * * *

PROCEEDINGS

September 23, 2013

THE CLERK: The court will now hear civil Case 12-560-S-BLW, Saint Alphonsus Medical Center-Nampa, Inc., versus St. Luke's Health System, Ltd., for day one of bench trial.

THE COURT: Good morning, Counsel.

Before we start, I thought I would mention this is a bit unusual. Because -- this is really for those in the audience more than the attorneys. Because of the nature of these proceedings, there is a lot of very sensitive information that the parties are going to use during this process.

We have, through a -- I won't say "arduous" -- but kind of a long-term process, determined how those -- that information will be handled. It involved some agreements among counsel during what we call the discovery phase of this case. And now that we're entering into the trial phase, it still becomes very important for the court to have access to all information, including that information which may be deemed very confidential and privileged by the parties. It may impact their competitive posture in the marketplace.

And for that reason, the court has agreed to allow the parties to designate even for trial some materials that will

only be available to the court and will not be shown to the public or made part of the record that is accessible to the public.

I have always been very committed to the idea of an open court. And, in fact, we will -- we're going to be discussing with the attorneys the idea of allowing even live blogging during the process of the trial. I have no philosophical problem with that. But, of course, that has to give way when there are serious financial interests of the parties that could be jeopardized or injured if certain information does become public.

So, to achieve that balance of maintaining an open courtroom but, yet, also preserving the privacy or the information which might be deemed to be trade secrets, there will be occasions during the trial -- and, in fact, even this morning -- when I will have to, in essence, clear the courtroom and excuse everyone from the audience to remain outside the courtroom while certain evidence is presented to the court.

It is an awkward process, but we could come up with no better process. So you have my apologies in advance for this inconvenience. But it is, in the court's view, absolutely essential to allow this matter to be fully presented to the court in a manner which will allow me to hopefully, at the end of the day, issue a reasoned decision

and a fully informed decision after considering all of the evidence at issue in this proceeding.

So, just so you have that as kind of a heads-up. We'll start this morning -- Counsel, just for your information, I'll tell you exactly when, but we'll take a break roughly around 10:10 or so. I'll try not to interrupt your opening statement. I'll try to find a time -- we'll either start a little bit -- take the break a little late or a little early, if need be, so as not to interrupt your statements.

We'll start off with the plaintiffs. Mr. DeLange, I think you're going to start us off with your opening statement.

MR. DeLANGE: Thank you, Your Honor.

Counsel, my name is Brett DeLange. I'm a deputy attorney general. I'm chief of the Consumer Protection Division in the Office of the Idaho Attorney General, assigned the responsibility of enforcing Idaho's Competition Act, as well as the applicable federal antitrust laws.

I represent the State of Idaho in this matter, and I'm here on behalf of Attorney General Lawrence Wasden. And with me, Your Honor, is Special Deputy Attorney General Eric Wilson.

My office has worked very closely and in conjunction with my colleagues from the Federal Trade Commission, and I would like to introduce them to you, as well. Some of them

have already appeared before Your Honor. With me for the Federal Trade Commission are attorneys Tom Greene.

MR. GREENE: Good morning, Your Honor.

MR. DeLANGE: Peter Herrick.

MR. HERRICK: Good morning, Your Honor.

MR. DeLANGE: Another attorney who will be appearing before you is Henry Su. He is working on trial matters outside the courtroom this morning.

The Federal Trade Commission and the Office of the Attorney General have been working on this matter intensely for quite some time. Indeed, our investigation of the St. Luke's then planned acquisition of Saltzer Medical Group started well over a year ago.

We, the government plaintiffs, interviewed numerous parties. We reviewed voluminous data. We researched a variety of issues. We even met multiple times with representatives of St. Luke's and the Saltzer Medical Group to understand their side of the story.

When all was said and done, the government plaintiffs were left with the abiding conclusion that the St. Luke's acquisition of the Saltzer Medical Group violates the law. We sought informally and amicably to have the transaction not close. We were not successful, and St. Luke's and Saltzer closed on that transaction last December.

The private plaintiffs filed their suit in November.

The government plaintiffs, receiving assurances from St. Luke's that the transaction could be unwound should we prevail in any action that we might bring, completed our investigation. And having concluded that the now-closed transaction does violate the law and that this matter is a case of great import to the State of Idaho, we filed our lawsuit in March of this year. So here we are today.

Discovery has been very intense. And as Your Honor actually has noted, the parties have worked cooperatively to gather the evidence and the expert opinions that Your Honor will hear and receive.

So what is this case all about? Let's start with what this case is not about. This case is not about the Affordable Care Act. This case is not a debate about how healthcare can or should be improved. This case is also not about what someone hopes to do in improving healthcare as a result of that debate. Rather, what this case is about is the proper application of laws enacted both by the Congress and the Idaho legislature which uphold competition in part by prohibiting acquisitions in any market that may substantially lessen competition.

It is these laws, Your Honor, that provide the lens by which we're to hear the evidence and consider the arguments; laws which express the policy of this nation and this state, namely, the competitions to be upheld, competitions to be

protected, competitions to be defended; and threats to it, such as acquisitions that may substantially lessen that competition are to be barred.

These laws also provide the principles and foundation by which the evidence is to be judged and evaluated and weighed. Our antitrust laws rest, as the United States Supreme Court has stated, on the premise that the unrestrained interaction of competitive forces will yield the best allocation of our economic resources, the lowest prices, the highest quality, and the greatest material progress, while at the same time providing an environment conducive to the preservation of our demographic, political, and social institutions.

So those are the laws that we're operating under today. Those are the laws that provide the context by which we are to consider the evidence that will come in, and their application here is the issue to be decided in this case.

Thus, the government plaintiffs will discuss now, the facts of this case, the expert opinions expressed, the relevant documents and the data connected, all related to this fundamental question: Does or -- well, actually, may St. Luke's acquisition of the Saltzer Medical Group substantially lessen competition in certain lines of physician services in the Nampa area? That's the issue, Your Honor.

We think, of course, they do. That's why we're here. And, hence, further, the government plaintiffs will also show that allowing this acquisition to stand would harm Idaho consumers; it will harm Idaho businesses; it will harm Idaho employers who would ultimately see higher costs and potentially less innovation and poorer services.

My colleague Tom Greene will now proceed to discuss the facts and opinions which the government plaintiffs will provide the court in this case.

Mr. Greene.

THE COURT: Thank you, Mr. DeLange.

Mr. Greene.

MR. GREENE: Thank you, Your Honor.

Apropos of our common problem of protecting the confidential nature of some business documents, I will be asking Your Honor to shut off the public screens occasionally. Not yet.

THE COURT: All right.

MR. GREENE: I will certainly let you know, but I did want to indicate for the audience there will be these little moments of awkwardness in which I will be broadly speaking, discussing what you are seeing, but it won't be being shown to the audience.

Let me start at the beginning. Let me set the stage just a bit, if I may, Your Honor, just in terms of who the

parties may be in this proceeding.

The defendant, the principal defendant in this case, of course, is St. Luke's. This is the largest healthcare system in the state of Idaho. It has facilities and physician groups all across the state. It literally employs hundreds of doctors and other professionals.

Particularly apropos of St. Luke's acquisitions is the bullet point at the bottom of the slide, which indicates that circa 2011, in one of its many acquisitions, St. Luke's acquired the Mercy Physician Group. The Mercy doctors, now St. Luke's doctors, are located specifically in Nampa, which is ground zero for this litigation. So, conceptually, from an antitrust perspective, this is a horizontal merger as the Federal Trade Commission and the State of Idaho view it.

But the premise for that is the fact that St. Luke's actually feels primary care physicians in the Nampa market, those physicians compete directly with Saltzer physicians who are being purchased.

St. Luke's also -- although we have not alleged it -- competes with respect to ancillary services like laboratory services and things of that nature before the acquisition. The Saltzer physicians charged very little or relatively less than St. Luke's, and we'll be talking about those numbers in this opening statement.

But the principal point of contention and focus of this

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particular antitrust analysis is that these physicians, the Mercy Physician Group, compete with the Saltzer Group, and that Saltzer Group is going to be acquired by St. Luke's.

According to Dr. Randell Page, this was the lead negotiator for the Saltzer Group. One of the major reasons from their perspective for doing this deal is that they perceive St. Luke's to be the dominant healthcare provider in the Idaho markets.

Basically, what -- this next one by the way, Your Honor, is going on an AEO slide. So, essentially, they wanted to hook up with the big guys, and they were able to do so by way of this transaction.

The next slide, Your Honor, basically just gives a brief indication. This was drawn from some analysis and testimony done by the chief financial officer of St. Luke's, and it indicates generally the dramatically upward-sweeping revenue curve that has been enjoyed by St. Luke's. So roughly at about the same time it begins a wave of acquisitions, its revenue stream begins to increase dramatically.

And you will note, Your Honor, that in the next three years, that revenue stream is expected to increase even further. And I won't call out the particular numbers because it's been designated by St. Luke's as attorneys'-eyes-only material.

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Saltzer is perceived by St. Luke's executives -- I'm looking at a slide replicating testimony from Mr. Castledine, who is director of business development. His job was to go out and basically speak to independent physicians groups and discuss the possibility of joining with St. Luke's. He did a very careful analysis looking at the numbers of physicians. And he concluded that one of the advantages to St. Luke's of the deal was that it would give them a dominant share in the Nampa market.

The next slide, also designated AEO by our colleagues at St. Luke's, this is the results of an analysis done by KPMG, a national -- actually, an international consulting firm. KPMG, as part of an analysis of financing, structured financing deal for St. Luke's, concludes that St. Luke's is dominant -- I mean, that's fairly obvious -- but it also indicated that --

THE COURT: Mr. Greene, there may be a technical issue.

MR. GREENE: I'm sorry. -- that Saltzer -- I'm sorry.

THE COURT: There may be a technical issue. You have referred to multiple slides, and I think we are still seeing the first slide. Perhaps you could check with --

MR. GREENE: You're absolutely right, Your Honor. The KPMG analysis indicates that Saltzer within the

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Nampa community is the dominant healthcare plan, the dominant provider of primary care services, and that it has already developed at least some amounts of leverage in that -- in its dealings with the payors, like insurers Blue Cross of Idaho, Regence, Blue Shield.

We're now going to switch to the acquisition. I'm going to ask you to keep the screens dark.

Before you is a slide which basically lays out the terms of the deal. I think I'm just going to call out just a couple of them. There are monetary figures in this slide. I think there are just a handful of things I want to underscore.

Firstly, as a result of this transaction, St. Luke's will represent Saltzer in its negotiations with payors. So it will be a St. Luke's negotiator that will represent whatever market power Saltzer has at the bargaining table with payors.

The deal is structured as a contractual arrangement that doctors have signed up for what's called a "Professional Service Agreement." These things are called "PSAs." The testimony will make clear that this is every bit an employment relationship. These are essentially employed docs. Sometimes in the trade they are referred to as "owned docs"; although, that seems a little pejorative to me.

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The bottom bullet I think is an important one, potentially, since the other side has suggested that remedy may be an issue from their perspective.

I will only note that there is a form of payment in the deal involving several millions of dollars of income to Saltzer that would actually stay with Saltzer in the event of an unwinding, which I think gives the court a little more flexibility when and if you want to consider what we think is the appropriate remedy here.

The deal points are, I think, pretty straightforward here. They have been sort of masked, I think, by significant discussions about the Triple Aim and things of that nature. But the basic money parts of the deal are fairly straightforward.

The slide you are looking at basically captures what Saltzer gets out of the deal. And what you're seeing is a significant increase in the payday for the doctors. This is a substantial double-digit boost in their pay. That's the money side of what they get.

The next slide captures what I think is the essence of the transaction from the perspectives of St. Luke's. I won't read the numbers here, but I think I can fairly characterize the basic deal terms is they are going to pay more for Saltzer, and they are going to charge more for Saltzer. So this is a pay-more/charge-more deal,

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notwithstanding what we have heard from many in the public press.

I think you can now go back to the public screens, Your Honor.

The applicable law I have called out, since I'm the federal guy here, Clayton Act, Section 7. There is an analogous provision in the Idaho law, but the basic analytic structure is the same under federal and state law.

Section 7 of the Clayton Act calls out a couple of things which I think are important here. Firstly, it applies -- though it is a very important federal statute, it applies to any line of commerce anywhere in the country. So Nampa is a perfectly appropriate market for purposes of Section 7. Submarkets within Nampa could also be perfectly appropriate markets within the compass of this statute.

And what is to be done here is to determine whether or not this transaction may substantially lessen competition. There is no requirement imposed upon the plaintiffs that they be able to show that it does absolutely. This is a forward-looking legal structure which is designed to protect the economy in a forward-looking sort of way from incipient anticompetitive problems.

The structure of analysis is relatively unique. I mean, it's not different from some other kinds of law, but the most important aspect of this is a very important

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presumption. And that presumption was first articulated in this case, Philadelphia National Bank, which you can tell, from the typography of the opinion, is somewhat old.

But basically, the -- this case says that you can presume anticompetitive effects based on concentration. This is an essential element of this jurisprudence. If there is concentration, there is a strong presumption that it will have anticompetitive effects.

That is a rebuttable presumption that also flows from Philadelphia National Bank. But if we start with a presumption, then the burden shifts to the other side, and there will be very specific evidentiary requirements for how they prove up, you know, things that might offset this anticompetitive effect.

This presumption of illegality runs through the whole DNA of merger law. I have cited to you Rockford Memorial. This is an opinion I quite like. Plaintiffs won, for among other reasons is why I like this case, but it's also a very nicely thought-through decision by Judge Posner of the Second Circuit. And he, too, basically says the defendants' immense shares in a regionally defined market create a presumption of illegality.

So once the plaintiffs show the concentration, the burden shifts dramatically. And at that point, we could actually stop. We will not stop our presentation, but we

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could certainly based on the law.

The structure of this case law is that in order to provide a counterpoise, if you will, to the presumption that a highly -- an acquisition resulting in a concentrated market will have anticompetitive effects requires certain showings. So entry -- entry -- the idea here is basically is a quite simple one, which is: If there could be entry into a market, then that would offset concentrations. So a very straightforward idea.

But both the case law and the horizontal merger guidelines that would guide the prosecutorial discretion of both the Federal Trade Commission and our colleagues at the U.S. Department of Justice is that entry must be timely, that is typically within two years, it must be likely; you can't speculate; there has to be very clear evidence that there will be entry; and, finally, it must be sufficient.

So if we create a St. Luke's Saltzer which has an enormous share of the market in Nampa, Your Honor would have to find that the new entrant or entrants would be as substantial or have as substantial effect --

That would be good.

-- substantial effect on competition as the newly remuscled Saltzer-St. Luke's.

The next point is that -- and this actually is the case law itself. I mean, this could be a rhetorical flourish on

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the part of plaintiffs, but the defendants actually have to show that their efficiencies are, quote, extraordinary, close quote. This is not maybe some of them, maybe a little bit; they have to be extraordinary.

And this is not a rhetorical flourish on my part. This is the case authority. This is the standard that both the Supreme Court and district courts across the United States have embraced as necessary, so they need to make a showing that is extraordinary.

THE COURT: Mr. Greene, has there been any argument made that in terms of considering whether those extraordinary efficiencies have been achieved, that they kind of expand beyond the more historic model of healthcare, the fee-for-service, that -- and into more integrated healthcare and whether or not that can be the kind of extraordinary procompetitive effect? Or is that just simply inherently anticompetitive, and so that's not even part of the discussion?

MR. GREENE: I think, fundamentally, Your Honor, there is a falseness in that in the sense that what you're mimic -- speaking to is something that I think our colleagues on the other side have argued in multiple -- about on multiple occasions. There is no fundamental necessary dichotomy or tension between antitrust and competition on the one hand and clinical integration on

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the other side. I'll have a slide later in the deck which speaks to directly the statutory structure of the Accountable Care Act.

The Accountable Care Act and its implementing regulations make it absolutely clear that there is no question that antitrust and competition are regarded as enormously important forces that need to be protected and advanced in order for, as in any other sort of market, costs can be kept down, innovations will flow.

There is no notion anywhere, other than in some quarters in this courtroom, that you need to create a monopoly or have this enormous market share in order to integrate. There -- this is going on in every part of the United States. St. Luke's, bless them, they are doing lots of good things, but those good things are being replicated in healthcare settings all across the United States. So there is no tension between competition and healthcare. Indeed, as I'll point out --

THE COURT: What strikes me as really a pretty critical issue in this case because simply merging for merging or for a -- to simply take up a bigger market share obviously poses the very risks which you have addressed, but to do so if, indeed, it is necessary to perhaps change the dynamic of healthcare services, that may be a different matter. And I think sorting through that is going to be a

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major part of what this -- I think, at least from reviewing the briefs and what I have heard so far -- as being much about that. But go ahead. I didn't mean to interrupt.

MR. GREENE: I think the next point may be useful particularly to Your Honor on that point. Because one of the aspects of the case authority here is the notion that efficiencies, to count -- I mean, to even just throw them in the balance pan -- they have to be merger-specific.

So the idea here is kind of a less restrictive competitive harm sort of test, less restrictive alternative means. So if it is the case that those efficiencies can be obtained in a different way, a less competitively harmful way, then they don't count. So they are not merger-specific.

Amongst others, our expert, Dr. Kizer, who was the -- now teaches at the University of California Davis, formerly the person that reformed the Veterans Administration hospitals all across the United States, ran hundreds of healthcare facilities -- he will basically say, quite clearly and crisply, you don't have to employ physicians in order to get quality-of-care improvements. But I think that will be down the road during the trial.

THE COURT: Okay.

MR. GREENE: But I think, given your thinking, Your Honor, this is a specific piece of analysis that you

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might want to focus on particularly.

THE COURT: Okay.

MR. GREENE: The relevant markets, there is a kind of standard way of looking at markets. These are conceptualized as two-dimensional. One dimension is the product market; what is being sold is the product market. And then there the geographic market; where is it being sold. Plaintiffs tend to want to make these narrow. Defendants tend to want to make them as broad as possible.

In this particular case, there seems to be -- there may be a bit of kvetching about this, but the government plaintiffs have alleged an adult primary care physician market. This is the kind of doctor you would go to for your checkup. If your baby has a fever, if you have a fever, that's where you go. And then a general pediatrics physician market has been alleged in addition to the primary care market by our private practice colleagues.

In both instances, Dr. David Argue, defendants' expert, has indicated some sympathy to those being appropriate markets. So I think we may have a little bit of chatter about that. But I think, fundamentally, this will not be a major issue in this litigation.

Geographic market, however, is something that we think we have the better of, but that will be an issue. How wide is this? Does this include Boise and beyond? How do we

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actually sort of sort that out?

The basic idea here, Your Honor, is that if you can throw in more places, then that may change the concentration ratios to some degree. It turns out they don't change that dramatically, as I will show you.

But from our perspective, the appropriate market is Nampa. This is, of course, the second largest city in Idaho. It is a city which is some distance from Boise. There is obviously a very large rural area between the two cities. There is a significant driving distance between the two cities.

But when you actually look at the testimony which you will be hearing and which I'm briefly summarizing today, a wide range of market participants indicate that patients strongly prefer local physicians, the primary care physician. All plans -- that is, the payors, the Blue Crosses, the Blue Shields -- all agree that PCPs -- local PCPs are necessary to them being able to sell networks and plans.

And, finally, we have done a fair amount of analytic work, econometric work, which confirms that Nampa patients strongly demand local PCPs.

Just tagging up on some of the evidence, this is Patricia Richards. She is the CEO of something called SelectHealth. Ms. Richards is an executive with Select.

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And she -- Select is partnering with St. Luke's with an insurance product. And she makes very clear you need local primary care physicians and suggests that her metric is you need physicians close to home, within a few miles, and within a driving distance of five to ten miles -- five to ten minutes. That basically means the market is Nampa.

This certainly is the common-sense perspective of how the market should be done. If you are ill, you are not going to get in your car and drive 25 miles to another city. You want your physician to be close by, at least for the primary care services that you use most often.

So this is one of the business partners of St. Luke's telling you that this is a market which should be understood to be quite small.

Excuse me, Your Honor. I need you to close this next slide.

The next slide is from a business consultant. He does most of the financial analysis for St. Luke's in terms of its various deals, and he also indicates that patients prefer local services.

I think at the end of the day, you will find that the fact that people need services close to home is baked into the business planning of St. Luke's with respect to this deal, but this is yet another admission by someone who speaks for, I think, and certainly analyzes these deals for

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St. Luke's that you need physicians close to home.

I think the next one you can open, Your Honor.

Dr. Seppi. Dr. Seppi is now a quality-of-care chief for St. Luke's. He also indicates that it is very important to have access points for those patients close to home. So the close-to-home aspect of this -- I mean, this gets complicated with the econometrics and all that kind of stuff. But at a very basic understanding of how things work in a marketplace, people want their physicians to be close to home.

Ms. Richards also says that, from a payer perspective, she also needs PCPs close to the location of the patients that will use them.

I'm sorry, Your Honor. You can open the screen at this point.

Jeffrey Crouch with Blue Cross of Idaho. Mr. Crouch represents the largest payor in the state of California. They have, I believe, on the order of magnitude of 400,000 lives in this state. PCPs are necessary. Patients demand them. In his experience, BCI cannot offer a competitive network without local PCPs. And, finally, a network without PCPs in Nampa would simply not be viable in the marketplace.

Within the -- interesting. We do have a document which, interestingly, has not been designated as AEO. Nampa physicians market, indicating that Saltzer and Mercy

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physicians represent the majority of primary care and surgical providers in Nampa.

A couple of things here. One is this is an admission of the shares that will result from this deal. And on the question of geographic market, they are analyzing the market for business purposes as Nampa, which I think is not, at the end of the day, absolutely dispositive, but I think it's useful.

This chart, Your Honor, is worth I think spending just a few moments on. This is referred to by our economists as a "Pac-Man chart," just because it sort of looks like the little dots on a Pac-Man slide.

So when you look at this, the purple area is the town of Nampa. And you can see that there is a slight shading difference between two areas. The shading area on one side is Ada County on the right, and the shading on -- the white space on the left is Canyon County.

And the Pac-Man pie charts that are sitting in or near Nampa show various colors. You can see the purplish color is provision of services in Nampa. So these shares are actually very, very substantial. And then the red and the yellow indicate that people have actually gone to other places, either Meridian or some as far away as Boise, to get care.

So that indicates that there is a strong need for local

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doctors to serve local patients. Currently, the vast majority of people in Nampa are seeking care locally, and a handful are leaving.

When you look at the other -- in the other county, you find that the pattern shifts actually quite dramatically. The yellow and red become much more predominant, and the treatment by patients that live in those areas going to Nampa -- which, again, is the purplish area -- is tiny.

So there appears to be very little interplay. There is some, and, you know, this will be an issue in how one should address all of this. But you can see that there is almost no departure from local markets by people when they have a basic choice.

One of the things which has struck me about these -- this Pac-Man chart, particularly when you look at the folks in Nampa who are getting their care locally, what St. Luke's economists are saying is: Gee, since some people can leave and obviously do, you should, too.

So, basically, I think of this as the -- you know, it's the St. Luke's way or the highway, fundamentally, which is what St. Luke's is telling this court, fundamentally, and its economists will suggest in elaborate econometrics. But basically this is the situation: the St. Luke's way or the highway.

What St. Luke's proposes is, even if they get a

monopoly share or a very large share in Nampa, the folks who seek treatment in Nampa either pay more or they go a long distance, which they, at least at this point, don't want to do.

There is a notion which sort of fits here. There is an idea called "critical loss." This was used in a number of cases involving hospital mergers 10 to 15 years ago. It's subsequently been criticized by economists, including the economy -- economic expert being used by the Federal Trade Commission.

So critical loss, the basic notion is that if an A-side company in a merger, the acquiring company, raises prices, would prices -- would people in some fashion leave to a degree -- the idea here being critical loss -- to the point where it would defeat their -- their proposal to increase prices.

It kind of intuitively makes some sense, but it turns out it's very difficult to do and, also, from a technical perspective, dramatically widens the geographic markets. And that has been found to be not very helpful and certainly not very accurate.

But there are a number of problems with this analysis, specifically in healthcare markets. The first is that, as Mr. Crouch and specifically Dr. Dranove will speak to in some detail, pricing in these kinds of markets is set by

negotiations between payors and providers and has relatively less to do with patient preferences. So it is -- the real analysis is focused at a different level from the level that this analysis was initially designed to do.

Secondly, Dr. Argue fails to execute perhaps the most basic aspect of the analysis, which is to determine the elasticity or the willingness of patients to shift, do something different if prices rise. That is an essential first element. He just skips that part and suggests that he thinks it's probably there. But when you actually look at what he has provided in his report, he doesn't.

And it turns out, finally, that Dr. Argue has had some real problems doing the calculation. He abandoned his first version of this because he said it wasn't fully done. And then, from our perspective, the most recent one is not any better. But you will hear more about that when you hear from Dr. Argue and Dr. Dranove.

Dr. Argue does not offer any specific geographic market of his own. He has not specified the exact parameters of his geographic market.

Market concentration. Based on our view -- again, reminding Your Honor of the Philadelphia National Bank presumption, this is yet another case in which excessive post-merger market shares and concentration create a presumption that the merger violates the Clayton Act.

HHI, this is the Herfindahl Index, which basically involves the summing of the squares of the market shares. We discussed that in our opening pretrial memorandum.

In this particular instance, typically, there are three thresholds, if you will: unconcentrated markets, moderately concentrated markets, and highly concentrated markets. We are deeply into the highly concentrated market category.

THE COURT: Counsel, does the HHI and the Philadelphia National Bank standards take into account radical differences in the market structure of different sectors of the economy?

I mean, it seems to me that automobiles and perhaps healthcare, that there is only a certain number of competitors that can, for a number of reasons, really be part of the market. Whereas with other sectors of the economy, the concentration is going to be far, far less because it's much easier to enter the market and other reasons like that.

Now, a bank, for example. I'm assuming the Philadelphia National Bank had to do with banking, and we have seen --

MR. GREENE: It did. The law has some flexibility in that regard because it takes into account, you know, the ways in which businesses are done. You know, there used to be the idea of natural monopoly. Certain things were so --

a local public utility, for example, was thought to be a natural monopoly.

THE COURT: Public utilities are regulated. They're allowed --

MR. GREENE: Right. At some point, if it is a natural monopoly, then there is regulation. The rest of the market, from the perspective to the antitrust laws, should be -- there should be free and open competition.

Healthcare markets are somewhat different from other markets. Pricing signals are almost impossible to sort out for ordinary consumers. That's why the testimony I think you will find from the payors is particularly important from our perspective.

But I think you will have the opportunity under the law -- ProMedica, and I have cited a number of healthcare cases, and I will cite some more. Those do take into account the unique aspects of healthcare. But, at the same time, Your Honor, they also honor and follow the law with respect to the importance of competition in those same markets.

THE COURT: Okay. And I'm not suggesting that it should not. It's just that it does seem to me that a unitary standard would not make sense because markets are so radically different from -- as you go across the national economy. But, clearly, it's just a question of what factors

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might change that and what the numbers should be, not that we shouldn't apply the HHI standards or the Philadelphia Bank standards. The question is what adjustments would need to be made because of the nature of the market. And I'm assuming other cases -- other courts have done so and considered that question.

MR. GREENE: They have, Your Honor. And one of the things -- I have the first witness for Your Honor later today or tomorrow, and I'm going to spend some time with him talking -- trying to sort out and help Your Honor understand that one of the key aspects of this, unlike a market, say, for example, for the sale of fruit or apples, okay -- I mean that's -- there are daily, if not minute-by-minute announcements of the price. It goes up, it goes down, that sort of thing. That's conceptually the classic open market.

These, by contrast, are bargaining markets. Prices are set in basically one-on-one, small-group-on-small-group negotiations. So the way prices are set depend on people's perceptions of their clout, if you will, their muscle, their ability to negotiate. And from the payer's side of that, typically, it's the availability of an outside option.

So, for example, if you have -- in this case, actually -- an 80 percent share of the market in Nampa, the payer with would want to know: What is my outside option? What is my alternative?

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And as the payers look at those kinds of facts, they have to make some judgments about their negotiating power in that negotiation. Though these kinds of negotiations, these bargaining markets are interesting -- and you will certainly be learning about them -- the effects of those negotiations ripple throughout the Idaho economy.

Firstly, if clout is reduced, as we believe it will be here, on the part of those that seek to buy services from St. Luke's, now St. Luke's Saltzer, then prices will rise; employers will have to pay more; employers, in turn, in Idaho may face competitive disadvantages in the national marketplace because they are paying more for their healthcare. But at the end of the day, this market is substantially unique because it is a bargaining market, which you will hear a great deal about.

Turning Your Honor's attention back to the slide deck, our complaint initially, the government complaint, essentially alleged that the shares of the combined Saltzer-St. Luke's entity would be order of magnitude in the mid-60 percent range.

We have subsequently subpoenaed information from the various payers, and we have now done a determination of the numbers based on visits. So this is actually the shares of these two firms based on visits; basically, this is billing information. So, at the end of the day, St. Luke's Saltzer

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will have a nearly 80 percent share -- 80 percent share of PCP services, primary care services, in Nampa.

Even if we use a somewhat broader geographic market, including Nampa, Caldwell, and Meridian, this pie chart indicates that the combined firm will have a share of approximately 60 percent. So this is well over the presumptions that -- that are appropriate.

And then just let me put this in briefly in context, Your Honor. Philadelphia National Bank, this was 30 percent share. This was enjoined. Rockford, 60 percent share, HHIs in the five thousands. If you actually look at the Rockford opinion by Judge Posner, he basically said those shares were enormous.

You've got University Health, 3200 was the postmerger HHI; Cardinal Health, 3800 is the final HHI; H&R Block, 4600; ProMedica, 4300. And then finally, Your Honor, we have St. Luke's Saltzer, and that number is 6219. So that is the -- that is this case in the context of the broader jurisprudence of antitrust.

Let me turn briefly to anticompetitive effects. We don't need to prove this as plaintiffs, but we do think that there is some very interesting testimony and evidence in the record which indicates that there are anticompetitive effects already existing in this market.

I mentioned this point to you earlier, Your Honor.

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This is the idea that these are bargaining markets. So basically payers on one side. Payers bring money and customers, and then providers bring patients. And these come together to generate prices and networks, which are then sold to employers and subsequently provided to employees.

So this -- this is the -- the existence of the outside option, the ability to find an alternative that will serve a market like Nampa, is -- is the most important aspect of this. And then in specifically this instance, this acquisition makes health plans' outside options much less attractive. They just don't have the options they used to have before this deal came down. And I think we will talk at some length about what that may mean.

Our expert, Dr. Dranove -- who is actually one of the most interesting experts, I think, actually in this space at Northwestern University -- his basic conclusion is that this deal will enhance St. Luke's market power and give it the ability to increase price. That's the essence of the problem before Your Honor and the essence of I think what will be determinative here.

St. Luke's, itself, interestingly enough, understands this concept as well. This document basically states, "St. Luke's Treasure Valley recognizes that the market share in primary care is a key success factor critical to

effective negotiations with payers."

So people in this market, and certainly St. Luke's executives, understand what the deal here is in terms of a relationship between concentration and clout at that bargaining table.

The next document, Your Honor, is AEO -- actually, the next several documents.

Saltzer had its own consultant to help them through the deal. This consultant basically says, "Opportunities for improved managed care negotiations exist based on a higher number of physicians." This is, yet again, indication of clout.

The next one, Randell Page, the -- again, the lead negotiator for Saltzer. Dr. Page basically says: We didn't get this particular consulting -- this particular advantage. We couldn't get that. But now that we're going to be part of this network, we will be able to get it, so let's go try.

One aspect of this, Your Honor, is that -- and we have suggested this in our complaint -- is that the Magic Valley story may well be a past-is-prologue situation. Basically, the game plan they developed there is a game plan they want to execute in Nampa.

And you can see from this slide that they are basically explicitly saying: We see this type of negotiation, the one like they had in Magic Valley, as a precursor to what we may

be able to achieve across the region. So, having learned in the Magic Valley what works and what doesn't, then that is the plan here.

You can see, by the way -- this is a BCI document which basically captures historic price increases -- the third column over are the percentage increases for the Magic Valley arena. So they go -- you can see these are very significant increases, particularly when you compare them. And the last column has the hospital rate of inflation. And you can see that they are multiples of those numbers, and they're rising very quickly.

We also have evidence that, from St. Luke's, itself, we need critical mass to -- we need -- that relates critical mass to the ability to negotiate with payors and their understanding of that is quite clear.

It's also clear, interestingly, that St. Luke's would strongly prefer not to compete on price. You will see a number of documents indicating that, though pretty much every competitor in the United States economy regards competition on price as pretty much what competition is about, St. Luke's executives apparently don't. They would like to avoid this -- this -- this tiresome price competition in the Idaho market.

We believe that that is not a good idea, that is not appropriate, and it's not allowed under the antitrust laws.

Another AEO document. St. Luke's doing its own internal analysis of one line item, the one important one, that it will now charge more for in the Saltzer deal. So this is from one line item, and it's for one year. And those numbers are going to ripple out to payers and then employers.

The next slide is from their internal analyses of the advantage they will get -- you know, the higher costs, higher charges they will make -- now that they control Saltzer. And you can see at the lower right, for commercial payers, we are talking millions of dollars of increased charges. This is their analysis, not ours. This is not our economists. This is their person.

Idaho's largest insurance plan, Blue Cross, will indicate that -- that St. Luke's has used its market power previously, and they expect it to use its market power in the future specifically in the Saltzer transaction.

We have a Regence Blue Shield executive indicating just how important the Saltzer Group is in Nampa. I mean, when you think about the bargaining nature of these markets, if it's necessary to have Saltzer-St. Luke's in your network, that means that you don't have that outside option which keeps prices down.

We will hear -- you will hear from Linda Duer, who is the executive director of Idaho Physicians Network. This is

the network that is basically purchased or rented by some of the largest national health insurance companies in the country in order to compete in the Idaho marketplace.

She will indicate that she had huge problems with Magic Valley price increases; price negotiations have essentially stopped with her; and that substitutes in the Nampa region simply are not there.

I think, Your Honor, we can turn to "Entry," and you can turn the screens back on.

Again, recollect, Your Honor, that entry must be timely, likely, and sufficient. And in this case, that is simply not the case.

Two quick hits. Dr. David Peterman. He's the president of Primary Health. This is a group that practices specifically in the Nampa area. He has had great difficulty, great difficulty recruiting physicians into Nampa.

Nancy Powell, who was formerly the CFO of Saltzer, also indicates that even that firm, with its great reputation, was unable to recruit.

Randell Page indicates that -- again, Mr. Page is the -- Dr. Page is the chief negotiator for Saltzer. And a new entrant would be basically -- wouldn't have any patients and would have to build a practice from scratch. Obviously, huge difficulties in meeting the standards of entry.

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Entry will not offset St. Luke's additional market power. Dr. Dranove looks at this very carefully. It's a classic piece of antitrust analysis. His firm conclusion is that both the theory and the evidence indicate that entry will not work.

THE COURT: Mr. Greene, in a bargaining market, as you have described it, the entry into the market would not presumably be individual PCPs but PCP groups or groups coordinating with, say, Saint Al's or others to create a competitor that could then be engaged in bargaining for healthcare?

MR. GREENE: Yes. It would probably come in two potential ways. One would be the expansion of groups independent from St. Luke's Saltzer in that marketplace. It could also come in as new entrants. It's probably going to be a combination of both.

But when you actually look at the success rate of folks who are already in this market recruiting primary care physicians in particular, it's essentially terrible. They all complain about it. St. Luke's complains about it. Saint Alphonsus complains about it. It's just hard to get these physicians into these kinds of markets.

THE COURT: All right.

MR. GREENE: So, apropos of that, David Argue, the defense expert, was asked: Can you identify one likely

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entrant? And his relatively crisp -- and we appreciated it -- answer was: No. It's just not obvious that anyone would be coming into this market after the Saltzer-St. Luke's transaction occurs, and certainly not sufficiently so, from our perspective, that it would offset the obvious problems created by this deal.

There are a number of problems with the efficiencies claim. The first is conceptual but nonetheless important. It goes fundamentally to this question of merger specificity.

There is no link -- there is no necessary link between these acquisitions and quality improvements; there just isn't. Their numbers don't indicate that. They would like it to be. They have a post hoc ergo propter hoc analysis: Well, we hired some doctors, and we say we improved our care, but it's not at all clear that the one was necessary to get the second.

The second point here is that they have made, at least to us, some really quite extraordinary claims about improved morbidity and mortality. None of those claims have stood up to scrutiny. And at this point in time, there are no measurable benefits from St. Luke's use of its health information technology and certainly no evidence that this -- any benefits associated with St. Luke's is not the equivalent of or about the same as the kinds of improvements

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that are being seen at Primary Health, for example, that uses eClinicalWorks, which is the technology that Saltzer is using.

And, finally, there is no evidence that St. Luke's prior acquisitions or primary care physicians lowered the cost of healthcare. We looked at this closely.

Okay. Finally, there is a notion that we have had a nucleus theory idea offered by the defense, which is that: Well, we may not need to own or employ all of the doctors, but we do need a nucleus of employed physicians in order to improve quality of care.

So this actually has been a bit of a moving target. Dr. Seppi, in his deposition, basically said they needed 300 or 400. Since they already had 500, presumably they don't need Saltzer to do this.

Then Dr. David Pate, the CEO, indicated that he is currently doing this -- improving care from his perspective -- with two to three dozen physicians.

And then, most interestingly, Dr. Alain Enthoven of Stanford University suggested that: Well, I'm thinking something like four to six per specialty. So when you have got already 500 doctors in your stable, there is no indication here that you need to have this many doctors for your nucleus or your core to be employed in order to gain efficiencies.

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That's AEO, Your Honor. Let me have you close the screen.

St. Luke's head of clinical integration, he is not even sure if they're going to reach clinical integration by the end of this decade. This is not a -- a statement that is consistent with the burden that the defense has to carry in this case.

The expert -- you can turn it on again -- this again is Dr. Enthoven in his deposition. "Do you have a view of how long it takes to fully change the incentives?"

"I would have to say I think maybe a decade or more."

And then he goes on to say, talking about this integrated care program that St. Luke's aspires to, "This is a complex and perilous route, and others trying to take this route have tripped and fallen."

These are not good words to hear when you're being asked to offset this speculative enterprise when you know that they're going to get an 80 percent market share in an important market in the state of Idaho.

The St. Luke's strategy, according to one of their own doctors -- this is a statement by one of their medical directors, surgeon Dr. Huntington. I deposed Dr. Huntington. This is one of his emails. "But let's be realistic. Employing physicians is not achieving better cost. It is achieving better profit."

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So, from our perspective, Your Honor, this is really what this is about.

And then, finally, there is no evidence that prior PCP acquisitions actually lowered costs. Our experts spent a fair amount of time and a lot of computer time looking at this. And he saw two patterns: either no significant spending changes or increased total spending. There was no indication that, at the end of the day after all these various acquisitions, that costs -- costs for consumers had gone down in any way. And in some of his scenarios, costs had actually increased.

And he suggests that there is some possibility -- actually, some substantial possibility that this may result in cost increasing inefficiencies.

The efficiencies are not merger specific. They didn't consider viable alternatives. The executives have acknowledged that there were alternatives that they could have followed but did not. Plaintiffs' expert, Dr. Kizer, will indicate that all of the purported benefits could be achieved using less competitively problematic alternate means.

And it turns out that various executives from St. Luke's agree that that's true.

And if you would darken the screens, Your Honor, for the next couple of slides.

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So you have the VP of physician services indicating that even if the deal is undone, there would be a relationship -- presumably a productive one -- between St. Luke's and Saltzer.

One of the things that we have heard that -- and you have also got this language, and then let me go to this. One of the things that has been suggested is you need to employ docs in order to provide -- doctors in order to provide them a financial incentive to pursue quality.

It turns out that the vice president of payer relations at St. Luke's has indicated quite clearly, based on his experience at Advocate Health, which is a Chicago-based healthcare area, that it's very -- that at least when he worked there, they provided significant financial benefits to independent physicians if they met quality metrics.

That is something that has been allegedly not possible here in Idaho. But at least in Chicago, where one of their major executives sort of cut his teeth, that was certainly appropriate and possible.

If you could light the screens again, Your Honor.

One of the statements made in the pretrial memorandum is that one of the major benefits of this deal is a robust electronic medical record. Well, it turns out that EMRs are a good thing. The United States government and its taxpayers have been spending billions of dollars in support

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of seeding of EMR systems across the United States, including money provided to St. Luke's.

And it turns out that the EMR system that St. Luke's is considering, they are going to extend that system to independent physicians. It's called the Affiliate EMR Program. This is one of the planning documents. They already have some people who are using this.

Dr. Kizer will testify, by the way, that you don't have to be on the same system. There are a couple of alternatives. One is there are interfaces; you can have one system talk to another. This is a classic EMR problem. Virtually every EMR provider in the country has specialists that sort out how to make one system talk to another.

The Idaho Health Data Exchange exists. This is a program that's partly funded by a federal grant. The design of that program is to facilitate -- its goal is to facilitate interaction of electronic medical records all across the state of Idaho, and it uses technologies that allow different systems to talk to each other.

And here is -- actually, I found this interesting. This is essentially a demonstrative we pulled from the website of Primary Health. This is a provider that provides some services in the Nampa area. And it turns out that Primary Health, like Saltzer, uses the eClinicalWorks EMR. And we actually look at what the EMR does, and you compare

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that with the claims and the things that St. Luke's says are the crucially important aspects of an EMR. All of those elements are already being provided by the eClinicalWorks program, and they are interacting with St. Luke's already.

And I think you need to darken the next slide, Your Honor.

There are a number of other defenses which we have not seen before, but we wanted to just tag up on them. The first one -- unfortunately, this is an AEO slide. This is a statement from the report of Dr. Alain Enthoven. Basically, I think of this as the give-monopoly-a-chance defense.

So the idea here is that Dr. Enthoven is very comfortable with the idea of a payer as long as it has what he thinks of as a good clinical integration program. They can be a monopoly from his perspective as far as we can tell. It may take some time, as he suggested; it may be 20 years; it's speculative; it's hard. But it's the give monopoly a chance.

I don't think Your Honor should give monopoly a chance under this circumstance, but you will certainly hear from Dr. Enthoven that that's something you can consider.

The next slide --

THE COURT: One of the arguments that St. Luke's makes is that in order to have -- I think the term is "risk-based contracting," that there does not to be, in

fact -- they don't use the term "monopoly," but there has to be a sufficiently large volume of patients and doctors and people who buy into that concept in order to make it work, so that they can actually contract to provide healthcare on that basis rather than fee-for-services.

Are you suggesting that, in fact, that's not true? That you don't need that large --

MR. GREENE: Yes. Exactly. I mean, the -- there is -- I mean, just based on your ordinary experience, you would think there would be a minimum number. It's kind of an insurance product. But it turns out that when you actually look at what's happening in the rest of the United States, risk-based contracting actually is not a new thing.

The State of California, for example, over a third of patients in the state of California are served under risk-based contracts. This is a brand-new deal here in Idaho, but some of those contracts are being provided by relatively small providers.

And I think one of the questions that we'll probably ask Mr. Crouch when we get to this is: Is there some something -- is there some minimum -- what would he think, since he is an expert on insurance.

I think what he will suggest, Your Honor, is it's much smaller than 500 doctors and one-plus billion dollars in

revenues. It just is not required.

Then we have the -- and you can open the screens again, Your Honor.

So now we have -- now we have the healthcare reform defense. This was in the pretrial brief. This is a very elegant and artful piece of work. Basically, the implication here is that there is some collision, there is some necessary conflict between the interests of the Accountable Care Act, which, of course, vouches for and supports the idea of clinical integration and antitrust.

Essentially, what Dr. Pate and his lawyers have told us is that: Gee, I can't integrate if these antitrust laws get in the way. I mean, I think it's fundamentally what Your Honor is going to hear. But at least from a federal government perspective, that's hokum.

When you actually look at the Federal Register, these are the guidelines, these are the regulations implementing the Accountable Care Act with respect to accountable care organizations. And it makes crystal clear that competition among ACOs can accelerate advancements in quality and efficiency.

The federal government -- at least CMS in charge of the Medicare program -- does not believe that it should incentivize the creation of ACOs where their formation would create market power. Amongst other provisions in these

regulations is a specific notification provision that lets the federal antitrust agency, the Federal Trade Commission, and the U.S. Department of Justice know about every one of these ACO formations so that we can take a look at it.

There is no war between competition and accountable care. It is a figment of the imagination of several, but it is not a figment in the -- it is not real; it is not the law of the United States.

Finally, the pretrial memorandum cited Professor Herzlinger. Professor Herzlinger writes and speaks frequently on healthcare issues. And the implication in the pretrial memorandum is that somehow she supports what St. Luke's is doing here.

I must admit we were a little bit flattered that the defense suggested that the government plaintiffs had their muscles rippling. We were sort of excited we had muscles that might ripple. But it turns out that, when you actually read Professor Herzlinger's work -- this is her most recent book, Who killed healthcare? -- she warns us -- and it's probably worth sharing with Your Honor -- that in prior -- in a prior wave of hospital mergers -- this relates to the hospital merger wave of the 1980s and 1990s -- that hospitals suggested and argued and were allowed to merge based on those arguments that healthcare costs would fall, quality would increase. This is a trope which you'll hear

in this courtroom for the next month. It turns out that that turned out to be not true. Costs went up and, arguably, quality declined.

She also specifically suggests that when hospitals buy doctor groups, that, itself, creates competitive problems. She specifically notes that when they buy a doctor group, they basically are buying the referral system that the doctor controlled.

So where work used to go to the most efficient provider that the doctor felt was appropriate, the usual result of these kinds of transactions is a referral shift to typically the more expensive hospital services. And she notes that these things -- though this is an aspect of vertical integration, she says specifically that, "Although vertical integration is an old strategy, it is not a good one. For one, it may work against the public interest by restraining competition." Exactly our situation here.

I think at the end of the day, Your Honor, a remedy is appropriate. And the antitrust laws indicate that the remedy that is the default remedy is divestiture. This is not out of the ordinary. This is the ordinary remedy that is provided in these kinds of deals.

So you have got the Dupont case. This is the seminal case in this space. Congress expressed its view that divestiture was the most suitable remedy in a suit for

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relief from Section 7.
California versus American Stores, which is a case I had a role in, divestiture is the most important of the antitrust remedies and should be in the forefront of a court's mind when a violation of Section 7 has been found.
You heard in this court -- actually, in this courtroom at the time of the preliminary injunction, a quite clear statement from the defense that it would be quite possible to unscramble this egg. We will not oppose divestiture on grounds that divestiture cannot be accomplished.
You are hearing a very different story in the pretrial memorandum. We will certainly mount evidence with respect to this kind of thing. I think, in particular, one of the first slides I showed you indicated that there actually is a source of funding for a transition when and if Your Honor decides that this is the appropriate remedy.
But we did want to conclude with the fact that we think we will be asking for this remedy at the end of -- at the end of this trial. I think, once all is said and done, this acquisition should be and will be properly found unlawful.
The premerger HHIs of 6219 create a strong legal presumption that this deal will have anticompetitive consequences. Testimony, documents, and empirical evidence all come together to confirm that the acquisition will have likely anticompetitive effects. There are no verifiable,

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merger-specific efficiencies that justify taking this risk. And, finally, the evidence warrants divestiture and a permanent injunction.
That concludes my opening statement, Your Honor.
THE COURT: Thank you.
MR. GREENE: Thank you.
THE COURT: Mr. Ettinger, we would normally take a break in about 25 minutes, but we could take a short break now. I'm going to assume you're going to take a little more than 25 minutes, but I don't know. I'll give you the option.
MR. ETTINGER: Your Honor, if we take a short break now, it might be a convenient way to try to clear the courtroom.
THE COURT: I'll avoid that. But, Mr. Powers, I'll probably go directly into your argument, though, after Mr. Ettinger, so if you could be ready to go. Then we'll take another short break and hear from, I guess, Mr. Bierig. And, I guess, Mr. Julian will be the cleanup hitter or whatever.
All right. We'll take a recess. We'll try to limit this to about ten minutes.
MR. ETTINGER: Your Honor, should we identify who ought to not come back after the break, given that I'm going to be very heavily AEO?

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THE COURT: Yes. It was my understanding, though, Mr. Ettinger, that you were only going to ask that people leave when you reach that point, or were you really requesting that it --
MR. ETTINGER: Your Honor, my first ten slides are -- even that's not true anymore. I think the better way to do it, unfortunately, because so many of the slides are designated AEO by St. Luke's, that we simply do it for the entire argument otherwise I will get a little bit into it and we'll have to --
THE COURT: What I will do then is exclude everyone from the courtroom except St. Luke's employees because it's -- and the term "AEO" is attorneys' eyes only. That's the designation given for privileged and sensitive materials.
So when we reconvene, everyone except St. Luke's employees -- who may remain in because they are -- they have been designated as sensitive documents by St. Luke's -- but everyone else will have to remain out. We won't start until that's been kind of clarified and perhaps the attorneys can review the audience and make sure we have proper mix here when we begin. All right. We'll be in recess for ten minutes.
(Recess.)
****** COURTROOM CLOSED TO THE PUBLIC ******

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THE COURT: Mr. Ettinger.
MR. ETTINGER: Thank you, Your Honor. By the way, I'm going to have one slide that is AEO Saint Al's, and I'll simply ask you to blank the screen when we get there, but only one.
THE COURT: All right.
MR. ETTINGER: Your Honor, I'm going to address the issues from the point of view of the private plaintiffs, both Saint Al's and Treasure Valley, generally, and then Mr. Powers will have some specific comments related to Treasure Valley.
I also wanted to start by saying while there is a large overlap between our case and the government's case, for the most part, we're not going to say anything about those overlapping issues because Mr. Greene has certainly addressed them. The only exception -- I'm going to begin with this, Your Honor -- is I thought I would add a couple quick comments in response to some of your questions to Mr. Greene and then jump into what I prepared.
Your Honor asked Mr. Greene, in terms of market share thresholds and HHIs, whether healthcare is any different, and I would simply add that Mr. Greene's chart where he showed you the market share is less than the shares here in cases that were enjoined, four of those seven cases with lower market shares were healthcare cases. So I think that

provides a lot of insight on that issue.

Your Honor, on the question of the Luke's --

THE COURT: Just a moment. What were the time frames of those cases? I mean, were they in the last ten years?

MR. ETTINGER: Yes, Your Honor. Not all of them. Some of them. They range from 1988 for Rockford to two years ago for ProMedica.

THE COURT: Very good.

MR. ETTINGER: Your Honor, on the quality, slash, integrated care defense, I just wanted to add a couple of things, some of which are particularly responsive to your questions.

I think we're going to have a lot of evidence that none of what St. Luke's claims that it would like to be able to do is merger-specific, that St. Luke's, itself, first of all, has taken many avenues, and many of the quality gains it claims occurred for reasons having nothing to do with acquisition of physician groups.

For example, St. Luke's has management services organizations that existed with the orthopedic and cardiology groups well before they were acquired, and the achievements in those areas are attributed by St. Luke's personnel to those MSOs, not to acquisition. That's one alternate way they can do it.

Number two, they are proceeding with clinical integration with their own network, Select Medical, which includes lots of independent physicians. And Dr. Pate has said publicly, and has affirmed in his deposition, that he expects to achieve clinical integration with that group, including the independents, by the end of 2013.

Third, St. Luke's, like every hospital in America, employs part-time service line directors who assist on quality, planning, and related issues, and those service line directors can be employed or independent. There is no reason why they can't be independent. They are sometimes for St. Luke's. They are frequently around the country. And that's a way to incentivize a doctor to help you on things where he is not doing direct patient care but still allow him to remain independent.

Fourth, as Mr. Greene mentioned, there is the affiliated EMR program, where St. Luke's plans to bring its electronic medical record to the independents. So once they do that, it will be crystal clear you don't need to acquire the group in order to have that shared medical record.

And fifth, the evidence will show that St. Luke's is working with independent groups, like Primary Health, like OB/GYN Associates, and has achieved quality gains by doing that. Another reason why you don't need to buy them in order for these things to happen.

Despite all those available options, many of which St. Luke's is pursuing, Your Honor, St. Luke's also admitted -- Dr. Pate, St. Luke's CEO, admitted that until this year, St. Luke's has not devoted sufficient resources to clinical integration with independent physicians. I asked him, specifically, at page 165 and 6 of his deposition, quote, When did sufficient resources start getting devoted to clinical integration with independent physicians at St. Luke's?

Dr. Pate said, "I believe it was at the beginning of this calendar year."

So if they haven't devoted adequate resources to the alternative until this year, after this case was filed, how can they say, as they have said since December, that we have got to acquire the physicians to achieve these results.

Dr. Pate, also, I think, reaffirmed the speculative nature of this defense. We had some discussion in his deposition about: Can you do the very same thing in every respect with independent physicians through contract? He offered a contrary view.

And then I asked him, "These are open-ended questions; aren't they?" at page 162.

And he said, "Yes."

So St. Luke's is requesting to be allowed to do something that is otherwise clearly anticompetitive, based

on one theory of how to answer open-ended questions.

Finally, Your Honor, you asked Mr. Greene about: Do you need a certain minimum number of doctors or shares in order to do risk contracting? Well, I asked Dr. Pate, essentially, that same question at page 190. I said, quote, Have you made any effort or has anyone at St. Luke's made any effort to try to determine whether the scale necessary to manage population health in the Treasure Valley, what that means in terms of any particular market share levels?

And Dr. Pate said, "We have not."

So, you know, if this defense were to work, Your Honor, among all the requirements that Mr. Greene mentioned, it's got to be a numbers defense. It's got to somehow say: We need to have a market share at least as big as what we're going to acquire here in order to get these gains. Because otherwise, if you could do it without that kind of acquisition, without that kind of market share, it doesn't justify the deal. But St. Luke's has never connected the dots. They have never said, quantitatively, in any way, that we need a market share of X in order to achieve these gains and here is why. Dr. Pate's statement admits it. What Mr. Greene showed you about the core and the nucleus and the shifting numbers establishes it.

So with that, Your Honor, let me go on and talk about the issues where we do not overlap with the government, and

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get into my slides.
So, Your Honor, the part of the case that is unique to the private plaintiffs really concerns ways in which the Saltzer acquisition will result in other anticompetitive conduct, conduct that will be enabled, conduct that will be forwarded by the acquisition of -- and that will include two major categories, harm to network competition in the Treasure Valley and the steering off patients to St. Luke's and the resulting foreclosure of competition. And this, we believe, will harm consumers and harm competition, and that's what we're going to show. And these are activities that are already being undertaken and already being planned. And Saltzer will provide critical ammunition to allow St. Luke's to effectuate these activities.
Our case concerns the markets -- the primary care markets, as does the government's case, but it also concerns the hospital and outpatient surgical facilities markets because these events will affect all those markets, both inpatient hospital care and outpatient surgical facilities. So that's another way in which we go beyond the government's case.
So Your Honor, what I'm going to do is talk about network competition and then talk about foreclosure and steering and then talk about how those activities are going to harm competition, in the next few minutes. And to start

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with, though, before that, to set the stage, talk a little bit about primary care and its significance.
Your Honor, Mr. Greene talked about primary care as a separate market, but it's also important to note, as again Dr. Page from Saltzer said, primary care is effectively the gateway, the gatekeeper for all those other services. Primary care providers control the input to outpatient services, diagnostics, referral to proceduralists, meaning specialists, who then use the hospital. So the primary care doctor is the guy who starts the process in motion to decide all those things and, therefore, is critical to all the relevant markets, including the hospital and surgery facility markets.
Your Honor, this is just a simple schematic that shows the ways in which patients can get to the hospital or outpatient surgery facility from the primary care physician, either directly or indirectly through other vehicles, and we'll spell all this out as we go further in trial.
But in most cases, not all, but in most cases the primary cary physician is what starts it all off, and that's why the primary care physician is critical to networks, and that's why the primary care physician is critical to competition in all of these markets.
The other thing, just to set the stage, Your Honor, is that this case is, of course, focused on the Saltzer

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acquisition, but it is not only about the Saltzer acquisition. It has to be assessed in the context of what's been going on, that St. Luke's has made more than 20 acquisitions of physician practices over the last several years. And the case law that we have cited in the trial brief makes clear, under Section 7, Your Honor, is to look at all the transactions, look at the full context, the cases recognized, Congress recognized as far back as 1890 when they adopted the Sherman Act that you can't sue on every last transaction, so you have got to be flexible and allow the court to consider a series of transactions.
It may be too late to undo a lot of these, but, certainly, the effects of them coupled with Saltzer are important as long as Saltzer is a significant contributing cause. And we think it's far more than that.
So now, Your Honor, to get into network competition. First, real basics, talk about what we're talking about. A network is, basically, an aggregation of providers, Your Honor. So a network can get together hospitals, doctors, outpatient facilities, other providers, and offer this to either a self-funded employer or a payer. And the self-funded --
THE COURT: The payer is going to be an insurance company, typically.
MR. ETTINGER: Insurance company but also

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employers. We're going to talk about Micron, for example, today --
THE COURT: All right.
MR. ETTINGER: -- which directly dealt with such a network.
THE COURT: You distinguish employers from payers. I'm assuming, I guess, the private individual who has no insurance and is independently wealthier can afford to pay for it.
MR. ETTINGER: I don't know if any of them have called the networks lately, Your Honor.
THE COURT: All right.
MR. ETTINGER: But, basically, it's self-funded employers or payers where this will arise.
And just to throw out a little bit of the jargon that I may slip into, Your Honor -- and by the way, if I do beyond this, please interrupt me -- there is talk in the record about so-called "narrow networks" that include a limited number of providers, PPO networks, which, typically, in Idaho, include most of the providers. There is also talk about tiering, where you may have providers in a network but the benefit design is such that certain providers are preferred over others. Employees get a better financial break if they use certain providers over others. So there is a lot of ways these networks can develop that we'll be

talking about in this case, but it starts out with kind of this basic concept.

So, Your Honor, there are a bunch of competing networks in the Treasure Valley that we'll be talking about. Select Medical is the Treasure Valley Network that's anchored by St. Luke's that includes St. Luke's physicians but also many independent physicians. BrightPath, which is not on the slide, is the statewide network that hooks into the St. Luke's Select Medical Network, and they will be mentioned as well. ACN is the former name of and Saint Alphonsus Health Alliance is the current name of a network of independent and employed physicians and hospitals that include Saint Alphonsus. Mr. Greene mentioned the Idaho Physicians Network, IPN, which is a broad PPO network, lots of hospitals and doctors, including St. Luke's and Saint Al's. And that's the network that hooks up with national payers like Cigna, Aetna, United and provides their healthcare in Idaho, so it fulfills a very important function. The Imagine or Wise Network is the network that was developed to serve Micron and intended to serve a lot of other employers, but that hasn't happened, we believe, because of St. Luke's actions to scuttle it, and we will be talking about that this morning.

So, Your Honor, the first step is -- and Mr. Greene talked about this. I'm going to talk about it a bit

more -- Saltzer is critical to having a broad enough network. Scott Clement from -- formerly of Regence Blue Shield explained that. He said it was critical that Saltzer be part of the network. And the testimony will show this was not just an opinion. He ended up paying -- he ended up paying Saltzer more money than his standard rates because they wouldn't join his PPO network without -- without getting more money. And he felt he had to have them. So it wasn't just an opinion, it was an opinion confirmed by his business conduct.

But this doesn't just come from third parties, Your Honor. It comes from St. Luke's own executives. Mr. Billings, the VP of payer relations, said in an email that if Saint Al's kicked Saltzer out from ACN, it would, quote, cripple their own network, close quote. Those were his words in his email. And so when I asked him in his deposition, "What do you mean by that?" he said, "If they kick Saltzer out of their network, they're going to have a revolt on their hands from employees."

So Mr. Billings put it as strongly as we could possibly desire in making a case, Your Honor. This will cripple the network. Saltzer is that important. People who are using Saltzer doctors will revolt if -- if they don't have Saltzer.

By the way, Your Honor, this is interesting because you

will note in St. Luke's briefs, it says that what we have to prove to show harm to competition is that Saint Alphonsus would be crippled or that TVH would be crippled. That is wrong as a matter of law. We don't have to show that at all, but, in fact, it's pretty interesting that St. Luke's own witnesses say that standard is met. It's a higher standard that we have to prove, and it's met according to St. Luke's own witnesses.

So what is St. Luke's already planning to do, Your Honor? Select Medical and St. Luke's already resolved, before this case got filed, that they will have all their clinics exit the ACN agreement -- that's again the Saint Al's Network -- by July 1, 2013. Now that didn't happen because this case intervened. But I asked Steve Drake, the director of payer contracting, "That approval has never been rescinded; has it?"

And he said, "No, it has not."

Randy Billings again wrote another email, and he was talking about a particular contract with Saltzer. And then he said that should be reviewed and put into the exit queue just like we are contemplating with Wise, ACN, and even IPN, eventually.

Your Honor, this is a critical document because what he is saying is we're going to pull Saltzer and all our other docs from all the competing networks, not just the Al's

network. You will hear St. Luke's say that we're complaining just about harm to competitors, just Al's, not competition. This is everybody. This is the Wise Network. This is IPN, the broad PPO independent network that serves Aetna and Cigna and United. They want to pull their doctors from all of them. That's their plan. And if they have a critical provider like Saltzer along with all the others, you know, it's going to cripple those networks according to Mr. Billings' own words.

Finally, there is a trio of these documents, Your Honor, that we found. This is Toni Newman who works for Mr. Drake. Mr. Billings, Mr. Drake under him, Ms. Newman under him. And she said, "Our intent is not to participate in networks that compete with our own networks. We do not intend to allow clinics we acquire to remain in ACN. Our direction is for us to eventually terminate all ACN agreements."

So the plan is to pull the doctors out of the networks, and, certainly, having Saltzer is going to make that even more significant, even more competitively harmful.

Your Honor, a couple comments before I go on to the next slide, and that is, you're going to hear from St. Luke's about SelectHealth. SelectHealth is a payer from Utah that's come into Idaho working with St. Luke's, competing with other payers. St. Luke's says that's

procompetitive. As far as it goes, that's right, Your Honor. But, in fact, the SelectHealth story indicates why the Saltzer acquisition is anticompetitive. Why is that? Well, SelectHealth is using the BrightPath network, the St. Luke's-based network statewide that hooks into Select Medical. SelectHealth and Select Medical, Your Honor, by the way, are different entities, just happen to have that "Select" in their name.

Saltzer was already in that network before it was acquired. That network contains lots and lots of independent physicians. So St. Luke's is able to bring SelectHealth in from Utah and compete to its utmost with other payers without acquiring Saltzer. It already had Saltzer in the network.

So what changes if Saltzer is acquired? They can then pull Saltzer out of everybody else's network, and what would otherwise be procompetitive behavior, a new payer, will turn into anticompetitive behavior, a payer that is the only one that has access to these key providers.

Your Honor, one other point on this network issue that responds to what I think you may hear from St. Luke's. Saint Al's -- there are documents of Saint Alphonsus that discuss the issue of these providers. And Saint Alphonsus is in a very difficult situation, Your Honor, and that is because if Saint Alphonsus allows all the St. Luke's

providers in its network, they get to see all its secrets, all its strategies, all its plans. Nevertheless, it needs those providers. And as of today, there are 90 St. Luke's providers still in the Saint Alphonsus network. And that includes Saltzer. I think what these charts, what these slides show is that as of tomorrow, Your Honor, that's not going to be true if this transaction is allowed to go forward.

So, Your Honor, let's look at some of the networks, because St. Luke's argument is in here it doesn't matter, you don't need these providers in, the networks can create financial incentives to get employees to shift away from providers, and, therefore, it doesn't matter how big we get, it's really the payers and employers who have the upper hand. That's an argument you're going to hear, Your Honor.

And I think the evidence shows that's not true. Blue Cross and Saint Al's has a network called ConnectedCare without St. Luke's. Still has some of those St. Luke's doctors because they all have not yet been pulled out of ACN, as Your Honor saw. But, you know, how successful that network has been, Your Honor? It sold 220 lives. Not contracts with the employers. People. 220 lives in Idaho after a year, so -- and that's despite a 10 percent price advantage. Your Honor will hear about this, I think, from Mr. Crouch, and the fact is that this narrow network is not

attractive without St. Luke's.

Boise schools and Idaho Power developed incentive plans that would divert people from St. Luke's to Saint Al's because Saint Al's offered a lower price.

THE COURT: Just so I'm clear, BCI's ConnectedCare, then, was an attempt to create kind of a network of patients who would be directed to only the participating physicians and care providers, and it did not include St. Luke's. And after a period of time, it simply did not gain traction despite what you indicated was a 10 percent incentive?

MR. ETTINGER: Yes, Your Honor.

THE COURT: All right.

MR. ETTINGER: Boise schools and Idaho Power entered into programs where Saint Al's gave them a price break, and they created incentives for their employees to use Saint Al's, and they both ended the program. There are a few small employers who are now looking at similar things. It's too early to tell what's going to happen there. I think there is evidence that they need more providers.

Finally, Micron. I want to spend some time on Micron. Micron is a case where, so far, they have been successful in shifting business, but it's very much in doubt as of today. St. Luke's and Saltzer have done their best to scuttle the Micron network. And Micron is an extremely unusual case.

Indeed, Mr. Clement of Regence was asked about Micron, and he said, "I would not compare Micron to a commercial health plan. What happened with Micron was their industry wasn't healthy, employment had declined precipitously, and the company needed to save money, and employees needed to keep their jobs."

So Micron was willing to say to their employees, you know, you're going to pay a big financial penalty if you don't use the providers who are giving us a deal. Because they were in such tough shape, they were willing to do something that other employers in this area have not been willing to do, to say to people if you want your doctor, if you want your Saltzer doctor, you're going to have to pay more.

So let me talk a little more about Micron, because there is a lot to the Micron story, and, first, try to quickly run through a timeline that you'll hear more about, Your Honor.

So starting in 2008, Micron faces cuts in the chip business -- which is a difficult, cut-throat, innovative technology worldwide business -- faces price cuts of 50 to 65 percent. This is right out of their 10-K. They take a $1.6 billion loss. They announce plans to cut employment worldwide by 15 percent. They closed, by the way, their Fab 1 plant in Boise, and they announce cost-cutting

initiatives across the board.

What they do in healthcare is they hook up with Imagine, a company that has what's called the Wise Network. And the plan is we're going to pick a narrow number of providers, we're going to ask them to give us really good prices in exchange for a volume that will be incentivized because the employees will face a financial penalty if they don't use it. And they say we're going to do it in a tiered fashion, as I mentioned earlier, Your Honor. We're going to have the preferred high performance network, and actually on top of that we're going to have the Micron clinic for people who when they come to work want to go see a primary care doctor on site. But they are going to have the preferred network, the guys who give them the really low price for the preferred position; then the PPO tier, less financial incentives but still within network; and then those people who are out of network.

So Saint Al's and St. Luke's bid. Saint Al's bids once and then sweetens its bid. St. Luke's does not. Saint Al's was chosen.

Micron goes to Saltzer, and Saltzer refuses even to bid. Micron still says they need St. Luke's in that second-tier PPO network, and they need to develop a second-tier PPO network for employees who don't like the limited number of providers in the preferred network, and so

there is a national PPO network named "First Health" who is prepared to do so.

St. Luke's on the eve of the program starting sends a termination notice to First Health, and First Health withdraws. And St. Luke's does this in order to cause First Health to withdraw.

THE COURT: Now, wait. I'm not sure I understood what First Health was.

MR. ETTINGER: First Health, Your Honor, is a national company that has networks kind of like Select or ACN or IPN.

THE COURT: And Micron was working with First Health to develop this second-tier network, and St. Luke's withdrew from First Health?

MR. ETTINGER: Yes. St. Luke's was already in the general First Health network, which was offered by First Health, a national company to national payers coming into Idaho. St. Luke's had been a long-time participant. St. Luke's sent them a notice of termination with this pending, and First Health withdrew.

St. Luke's, internally, decided that if IPN participated in the PPO network, it would terminate IPN. And I am not saying that that's what caused IPN to decline, but the fact is St. Luke's was ready to take the same actions for another network if it did not participate, and

IPN ended up not participating. So at the last minute, the ACN network was used, which was not Micron's choice, because Micron already had Saint Al's as the preferred network. They wanted somebody else in the PPO network to have more choices. They weren't able to get them, so they went ahead anyhow.

And by the way, they then went back to Saltzer, offered Saltzer a better price, and it was better than the Blue Cross price Saltzer was already getting and accepting. Saltzer declined. Saltzer, ultimately, did come into the PPO second tier after it joined the ACN network in 2011, and that's another story I don't want to get into right now, Your Honor, but they did come in. Just for completeness I wanted to say that.

So nevertheless, the Micron network goes ahead, and it is successful. It saves Micron $27 million a year, according to Imagine, and it does cause patients to shift away from St. Luke's. And we believe it's because of the unique situation Micron was in. They really needed to cut costs. Their employees really needed their jobs and understood the circumstances. So Micron, uniquely, in this area, has been able to shift patients with financial incentives.

But nevertheless, Micron executives were not happy that they didn't have St. Luke's in the network. And they had

continuing discussions with St. Luke's. Up to this day, those discussions are continuing. And St. Luke's said, however, we will not join your Imagine Wise Network. We don't even want to talk to Imagine or Wise. We will not communicate with them. If you want to throw that out, that low-price, you know, high-volume approach and do something different that doesn't require us to engage in a bidding war, then we're interested. And because St. Luke's is so important and has so many providers, Micron has stayed at the table with them until this day.

In 2012, what happened then, Your Honor, is St. Luke's by then had acquired a number of the groups that were participating in the Micron network, and many of these were in the preferred network. They had agreed to pay the very low price to get the preferential treatment. St. Luke's bought them and St. Luke's pulled them out.

St. Luke's didn't pull everybody out, and Steve Drake admitted this, Your Honor, and it was because the FTC investigation was pending.

Today Micron is seeking alternative bids to replace a program in which they have saved $27 million a year. The reason is they're not happy because they don't have St. Luke's. And after five years, Your Honor, only one other employer -- no Boise area employer has joined the Micron network.

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And this is something I need to explain. The whole idea of what Imagine/Wise does is they go into a market, they find a sponsoring employer, they get started, they demonstrate how it works, and then the other employers join. And it becomes even more attractive to providers then because they have got more volume. And that's what they tried to do here. That's worked in a lot of locations around the country.

But here, after five years, after a program that saved lots of money, they have been unable to get a single Boise area employer to join. Why is that? Well, Steve Drake, again, Your Honor, said in an email discussing about what St. Luke's was going to do and why they, ultimately, did not participate in the PPO tier, "A very strong response is required to assure that Wise does not try to replicate this effort in conjunction with First Health for other large employers." St. Luke's was worried that price competition was going to spread, and it was determined to stop it, Your Honor.

Dr. Page made clear that Saltzer had the same concerns. This was when the second offer was made to Saltzer, the higher one, better than Blue Cross. So he said, "This is a decent fee schedule, but the con is we legitimatize a network and process that may end up setting a bad precedent for this area if it's successful."

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What's the bad precedent? Customers can use their volume, the offer to incentivize employees to shift the volume in order to get low prices. Well, that's competition. And St. Luke's didn't want it, and Saltzer didn't want it.

As I mentioned, Your Honor, Steve Drake terminated a number of these groups from the network when they were acquired by St. Luke's, but not all of them, because of the pendency of the FTC investigation. And this is where Mr. Drake admits that fact. So it would be even worse today if we didn't have the FTC as the cop on the beat and Your Honor overseeing it. And our concern is, obviously, if this case ends allowing the acquisition, these things are going to proceed apace.

Finally, Your Honor, I asked Mr. Billings about his -- St. Luke's attitude on this, the vice president of payer relations, and I said, "Isn't it true you took the position, from the beginning, and still take the position, that you don't want to engage in a bidding war with Saint Al's?"

"That's correct."

"And you think that's the right decision even though you don't have the Micron business as of today?"

"I don't want to get into a fee-for-service bidding war; that's correct."

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So after five years, after Micron being successful, after the volume shifting, that's not enough to cause St. Luke's to get into that bidding war and vigorously compete.

Now, is that because, Your Honor, we think they're bad people? We're not going to argue that. It's because of their dominant market position. This is a St. Luke's document where they talked about in this document, "Should we get involved in what they call a directed traffic environment?" And that's what Micron is. You know, where employers or payers say, you give us a really low price and we'll create incentives for our employees to use you. St. Luke's says, look, we have already got a 65-35 split. Right now we're dominant. We have two-thirds of the business. If we already have two-thirds of the business and we offer a -- and we give a discount to get business directed to us, if all that does is get us two-thirds, we are just breaking even and giving it up on the price. Their logic is impeccable. When you're dominant like them, it doesn't pay to compete on price, because you're already so ahead when you're not competing on price. So that's why St. Luke's wants to stymie these kinds of competitive networks. And the more acquisitions they're allowed to make, the more they're able to stymie them, and the more power they get, the higher share they get, the more

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incentive they have to stymie them. And that illustrates the kinds of anticompetitive effects that are present here, Your Honor.

So that's the kinds of things we're going to be showing on network competition being interfered with, Your Honor.

Let me talk about steering of patients and foreclosure of competition. And I want to begin here by talking a little bit about Saint Alphonsus Medical Center in Nampa, Your Honor. This is the hospital the evidence will show that was acquired by Saint Al's from the CHI chain when it was called Mercy Medical Center in 2010. The evidence is going to show that hospital was in pretty rough shape at that time. And Saint Al's has spent a lot of money and a lot of effort to not only improve the hospital but to make it more physician friendly, make the operating rooms have quicker turnovers so the doctors could be more efficient and so on. So that hospital has improved significantly, and after dropping for several years, its volumes have increased since Saint Al's acquired it.

That hospital has one critical vulnerability, Your Honor. As this Google Earth map shows, Saltzer is right next door on the same campus across kind of a narrow boulevard, in fact in the same parking lot as the hospital is. It has had a very, very close relationship with Saltzer in terms of geography, and it critically depends on Saltzer.

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So the issue is, for Saint Alphonsus Nampa, when St. Luke's acquires Saltzer -- the evidence is overwhelming, and I'm going to go through some of it, Your Honor -- that Saltzer doctors will not be sending the cases they have been sending to Saint Alphonsus Nampa, and that hospital will be tremendously harmed by it.

And right now, our economists, Dr. Haas-Wilson, did an analysis, and she found that 47 percent of the inpatient admissions at Saint Alphonsus Nampa are of patients who have a Saltzer primary care physician. 47 percent. And, Your Honor, recognizing -- I'm sure that, you know, the marginal case is always more important because you have got to cover your fixed costs, and more of the business goes to the bottom line -- and we'll spend more time on that in the trial. You know, if half your business is in jeopardy or even a decent fraction of that, that can be a terrible financial body blow to any institution and a terrible blow to competition, as I'll explain.

So on this issue of steering referrals of the business shifting if Saltzer is acquired, Your Honor, we have what I could call -- stretching the metaphor a bit -- what might be a 12-legged stool. We have documents and testimony from payers, from St. Luke's executives, from Saltzer personnel, and our economist has done analyses of the data in about eight different ways, looking at payer data, looking at

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inpatient, outpatient, ancillary services, cases where the patient was referred by the Saint Alphonsus Medical Group, cases where they weren't, looking in Boise, looking in Nampa, looking for primary care and for specialists.

Your Honor, this is what I, somewhat facetiously, called "the dog ate my homework" defense the other day when we were talking about the relevance of the acquisition of other practices. St. Luke's has offered a series of explanations for a variety of these pieces of evidence and a whole bunch of different ones. In every case it all just happens that these other alleged explanations happened at the time of acquisition. And at the time of acquisition, the business shifted. And our point is, well, maybe these explanations might be valid in one case, maybe two cases. But when you have got case after case after case under different circumstances and a wide variety of sources of evidence, it is impossible to explain in any other way except that the business is going to shift and competition for that business is going to be foreclosed.

So let me start with the evidence. First, Dr. Pate says -- this is uncontroversial -- you know, patients are very influenced by what the physician tells them. Not all patients, but most patients are going to go where the physician recommends. So if the physician's decision has been changed, then the patient behavior is going to change.

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The first evidence I want to go to is very specific on the Saltzer transaction. Mr. Reiboldt, again, Saltzer's own consultant -- and the context here, Your Honor, is that St. Luke's has publicly said that it is planning a new hospital in Nampa, though I don't believe it, as I understand it, has made the final, final decision. I think the testimony shows management has decided it will recommend it. And that was a heavy discussion with Saltzer. And St. Luke's said to Saltzer: Once the new hospital is up, we expect your volume at the new hospital. And Mr. Reiboldt said, yes, that's where you're going to be expected to work if you're acquired.

Again, once they are aligned fully with St. Luke's, there was the expectation that their business would largely go to St. Luke's. Mr. Reiboldt was quite frank about that.

The St. Luke's executives, basically, said the same thing. Mr. Taylor, the CFO agreed. That it is the intention of St. Luke's management to build a hospital in Nampa and staff it with Saltzer physicians.

Your Honor, I might add this is a little bit like the SelectHealth example. Is there anything anticompetitive about building a new hospital? In isolation, no. But if the building of that hospital is premised on acquiring the dominant physician group, controlling its referrals and shifting them to the new hospital, that's another story, and

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that's the concern here.

THE COURT: This is just kind of a, I guess, fundamental question, but I'm assuming there is nothing in the contract with Saltzer that would require referrals to -- by the participating physicians, the members of the practice, to St. Luke's facilities. Is it possible to create a circumstance or situation where the acquisition could go forward but there could be some limitations or contractual agreements even to allocate referrals, or does that interfere, then, with the doctor's role? And, in fact, why is it the doctors automatically refer or would refer within St. Luke's? There's a lot of questions in there, but I'm trying to kind of understand the dynamic of that.

MR. ETTINGER: Let me address each of them, Your Honor. First of all, I think there are lots of reasons why this happens, though it is not expressly spelled out in the contract.

THE COURT: Right.

MR. ETTINGER: Number one, you are going to see evidence -- in just a minute I'm going to show you --

THE COURT: Let me ask one question: Is there profitability? I mean, do the doctors participate in the profitability? Of course, St. Luke's is a nonprofit. But is there some financial incentive for a doctor to use the St. Luke's facility that's more subtle than contractual

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obligation to do so?
MR. ETTINGER: Yes, Your Honor. Subtle is an important word here. The contract does not pay them directly for any referrals. However, St. Luke's set their compensation based on formulas that considered not just the actual work they do, the professional fees, but the ancillary services they bring to the hospital, lab and imaging dollars, and so on. And they are under five-year contracts.
So at the end of the contract -- there is testimony on this -- if you're a doctor employed by St. Luke's or you're under a professional services agreement with St. Luke's, you know very well that if you're not going to be a team player after five years, they may say we don't want you anymore or we don't want to pay you the same amount anymore.
So while it is not expressly spelled out in the contract that any dollar payment is contingent on doing these things, the doctors understand the realities, and that's why they behave the way we have seen them behave again and again and again.
It's also true that the computer system, the electronic medical record creates default options. I'm going to get to those slides in a second. So unless you go to the trouble of going elsewhere, you are going to go to St. Luke's.
Finally, Your Honor, when you're working with somebody

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and you're there every day -- and by the way, when your staff is directly employed by St. Luke's and the staff has a lot of role in where referrals are going to, especially for things like lab and imaging, you're going to be a team player, and you're going to go along with what the team wants. I don't think there is any doubt of that. That's what the behavior shows.
So, Your Honor, I think there is no way that a court order could regulate this. First of all, you know, the doctors would say -- and I think this argument was made by St. Luke's back in December -- well, we should have a right to make decisions based on medical necessity. And in some particular case, the doctor might argue that it's medically necessary because one hospital is superior to the other. But how do you decide whether it's necessary in this case or that case? If suddenly in 80 percent of the cases they have made that judgment, is Your Honor going to decide whether that's a medical judgment or subterfuge? I don't think so.
The other problem, of course, is, Your Honor, that even if there were a mechanism, it doesn't address any of the horizontal issues that, of course, the government has raised in its case, and it doesn't address any of the network issues. You know, I think it's an inadequate solution to a small part of the problem, frankly, Your Honor.
So let me just go on with this evidence. I don't want

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to spend too much time on it. Mr. Roth, the CEO of St. Luke's Treasure Valley, said the same thing. They need the full support of Saltzer. Dr. Djernes of Saltzer in an email said St. Luke's, quote, declined to allow us autonomy in patient referral matters, close quote.
As I said, Your Honor, it's not in the contract, but that was the understanding of this member of the Saltzer executive committee. Declined to allow us autonomy in patient referral matters. That's what he said.
Nancy Powell, as Mr. Greene mentioned, was CFO of Saltzer. She is today, by the way, chief administrative officer of the Saint Alphonsus Medical Group. She left Saltzer on Halloween day, as I recall her telling me in 2011, but she was at Saltzer for much of the discussions here and had been their CFO for 13 years. And this gets at another aspect of this control.
The surgeons in Saltzer had part-time -- had an ownership interest in Treasure Valley Hospital and did a lot of cases there because they believed it provided better quality, lower-priced care. And they wanted to keep doing that. So first St. Luke's said, no, you can't do that. We want you to divest and quit using that hospital because we need your full support for the new hospital in Nampa. And then, eventually, St. Luke's abandoned that, by the way, after Saltzer, initially, voted not to do a deal with

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St. Luke's.
And St. Luke's then started working, through their consultant Peter LaFleur -- and this is what Ms. Powell is referring to here -- on an account model that would provide additional compensation for exclusivity. And she explained exactly what was meant by that: working out of St. Luke's facilities only. So they said to the surgeons: If you agree -- we're not going to make you give up your interest in Treasure Valley, but if you agree to work out of our facilities only, we'll pay you more. That's what Mr. LaFleur was working on.
Well, the surgeon said, no, we want to use Treasure Valley, as well, not exclusively but as well. And Mr. Reiboldt, the consultant, said St. Luke's refused to provide them with as much compensation as the other doctors got because they knew that these surgeons would continue to do a significant portion of their surgeries at TVH. If you're going to use a competitor, as well, we're not going to pay you as much.
And the difference was stark. The evidence shows, Your Honor, that the primary care docs in Saltzer got 30 to 40 percent increases, I think some greater than that. The surgeons were offered 5 percent increases. And St. Luke's own consultant said that was under market. And the surgeons, not surprisingly, because of this and other

reasons, said we don't want to be part of this deal, and a number of them are now working for Saint Alphonsus because they didn't want to be forced to give up their interest in TVH and give up using TVH.

So just some of the other evidence of this issue, Mr. Orr, the former director of physician services, spoke of St. Luke's historical willingness to preferentially direct patients to St. Luke's affiliated practices.

Under the Epic system, Your Honor, all referrals auto default to internal referral type, the point I was making. The medical record system effectively directs the referrals.

Your Honor, one other form of evidence on this. This is an example Mr. Fletcher, the COO of St. Luke's, presented to the board -- I think it was the Treasure Valley board in this case -- the acquisition of three groups: the Cardiovascular and Chest Surgical Associates, Boise Orthopedics, and Women's Clinic. And in his write-up in telling the board what it wanted to know as to whether or not to approve the deal, he said it was expected these groups would be exclusive to St. Luke's. And I asked him, "What does that mean?"

And he said, "It was expected," quote, they would end up doing most of their work at St. Luke's, close quote. So when St. Luke's buys these groups, it expects to get their business.

We have testimony from lots of doctors on this. Just one example: Dr. Barresi testified he had done most of his cases at Saint Al's until his group, Boise Surgical, was acquired. The group then gave up their privileges at Saint Al's and stopped doing surgeries at Saint Al's.

Your Honor, at least in the perception of some St. Luke's executives, Dr. Bathina, who is the president of St. Luke's Idaho Cardiology Associates, this is so strong that he felt that he would have to refer to a pulmonologist from Saltzer after the acquisition, "when we are fully aware that they offer a far inferior product," close quote.

So it was the perception of this president of one of the St. Luke's groups that referrals were controlled tightly enough that they had to refer to somebody they thought was lower quality. And if that happens, certainly, competition is foreclosed.

Your Honor, this was enough of a concern to St. Luke's that it tried to cover up the evidence. Kathy Moore is the COO of St. Luke's Treasure Valley. The proposal for the Boise Surgical Group, Dr. Barresi's group, said in the proposal as written that surgical volume is currently divided between St. Luke's and Saint Alphonsus. It's anticipated that the surgical volume will migrate to St. Luke's over time. Ms. Moore in an email crossed out that language and said, "See deleted portion. We can talk

to this, but I don't think we want it in the document."

Now, Ms. Moore in her deposition, said: Well, I didn't want it in the document because it wasn't true. Well, then, why is it okay to talk about it? Clearly, her desire was not to create a paper record of what they're doing.

So, Your Honor, there is also the data. You saw what Dr. Haas-Wilson came up with in December. Since then she has been able to look at far more data. Payer data as well as Saint Al's data, outpatient as well as inpatient. The pattern's very clear: After the groups are acquired, there is a big shift from Saint Al's to St. Luke's. This shows the same thing on the outpatient side.

Your Honor, you may remember a chart like this in December. This is updated with the new data, and it shows after the acquisitions the amount of this business that goes to -- that goes to Saint Al's drops precipitously and quickly. These are cross groups: primary care and specialty.

So, Your Honor, as I said, the 12-legged stool, there is a huge amount of evidence supporting this conclusion about referrals. There can't be any serious doubt about it.

Finally, though, Your Honor --

THE COURT: That last slide, I assume that will be shown as part of the evidence, as well?

MR. ETTINGER: Yes, Your Honor.

THE COURT: Okay. Go ahead. I was going to try to -- go ahead.

MR. ETTINGER: Okay. Your Honor, the final piece of this is pretty intriguing. So, Your Honor, of course, said in deciding not to grant a preliminary injunction and to allow this deal to go forward, that you assumed, paraphrasing, that things weren't going to change until trial. And indeed Saltzer agreed to provide the attorney general with survey results of what was happening. But the survey results show that even though, presumably, the Saltzer doctors have been told, you know, we're supposed to maintain the status quo, some of them, now that they are in the new team, or their nurses, now they're employed by St. Luke's, nevertheless started the shift. Because what we see here is that far fewer patients who prefer Saint Al's are referred to Saint Al's, and significantly more patients who are -- who are preferred -- who prefer St. Luke's are referred to St. Luke's, that the referrals are tilted towards St. Luke's as compared to the patient preferences.

And if they're doing it -- this is not the kind of thing we have seen in the other charts when they actually acquire the earlier groups where everything switches, but this is while the cop on the beat is paying attention and getting reports. And nevertheless, the shifting is already occurring, so what it says is: How bad is it going to be if

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this transaction is approved?
Your Honor, let me go on to harm to competition, but one thing I want to say about what St. Luke's may talk about here is St. Luke's may say: Saint Al's doctors do the same thing. A couple of quick points on that.
Number one, I don't think it's true, but more importantly I don't think it matters. Shifting referrals is not a, per se, violation of the antitrust laws. The question is: Will it harm competition? And Saint Al's hasn't bought Saltzer. Saint Al's hasn't bought 20 other plus groups. Saint Al's is not dominant in these markets.
And what Your Honor is required to do under the antitrust laws is to look at the effect on competition. And all the vertical merger cases look at it that way. They do not simply say it's either always okay or always not. And here we think the harm to competition is compelling, Your Honor. Let me go through why.
First of all, as I said, St. Luke's has a dominant share in these hospital and facility markets already. 59.4 percent in inpatient. That is within shouting distance of a monopoly, Your Honor. And in inpatient it really only has two rivals, Saint Al's and West Valley, but West Valley is off in Caldwell, and, virtually, all of its business is in Caldwell. So for the bulk of the Ada/Canyon County market, it has one rival.

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The reason why that's important, Your Honor, is that, typically, there is a significant distinction between harm to a competitor and harm to competition. Not true here. Here where the only way to preserve choice, the only way to preserve some competition is to make sure you have at least some vigorous rivals, when those rivals are hurt badly, competition is hurt badly.
Same thing, Your Honor, in the surgical facility markets. St. Luke's is dominant, and, essentially, its only competitors here, outpatient surgery, are Saint Alphonsus and Treasure Valley. So St. Luke's is very strong, and if it is allowed to make more acquisitions and get stronger that way, it's going to create an even greater problem.
By the way, there is a reason -- another reason why St. Luke's is so strong in the surgical facility markets, Your Honor, and that is it already bought up others of the competition. In the same period when it was buying up all these physician groups, it bought up two independent surgical facilities, the so-called River Street practice and another one, as well, Your Honor, where I think it was called Orthopaedic Associates. I may be remembering that wrong. They were groups associated with the orthopedic surgery groups that St. Luke's bought, facilities. So there used to be more competition in outpatient surgery. There is only two rivals now because St. Luke's bought up the others

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and thereby increased its share. So it's achieved dominance by other acquisitions. And now this acquisition, by changing primary care referrals to surgery facilities, will increase that dominance further.
Your Honor, one other difference, and Mr. Powers is going to address this, is that Treasure Valley is uniquely a low-cost, high-quality facility. It provides something different in the market. And so harm to it and even restrictions on its ability to grow are anticompetitive because they take away a key choice.
Your Honor, just to illustrate the importance of Saltzer in all this, I mentioned the 47 percent that Saltzer patients represent to Saint Al's Nampa. But when you look at the surgical facility markets, you see the same critical factor in terms of the Saltzer patients. The referrals from Saltzer, going back to Dr. Page's explanation at the very beginning of my presentation, starts with the primary care doctor, ends up at the facility. And so Saltzer has a substantially important role and can substantially shift this marketplace towards even more dominance by St. Luke's.
Here, looking at general outpatient surgical facilities, same thing as the last slide, except here it's really important, Saltzer is, to Treasure Valley, not as important to Saint Alphonsus, but critical overall for those very few rivals left in the market after St. Luke's has

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already bought the rest of the competition.
Excuse me, Your Honor. The next slide, I almost missed it. The next slide is the one I'm going to need you to blank out.
THE COURT: I'm sorry?
MR. ETTINGER: The next slide is the one I'm going to need you to blank out. It's the Saint Al's --
THE COURT: Okay.
MR. ETTINGER: So, Your Honor, another piece of evidence you're going to see is Saint Al's projections as to what's going to happen to Saint Alphonsus Nampa if it loses the Saltzer business. And a large part of this will happen even if it loses only part of the Saltzer business. The hospital is going to go into the red, and to maintain even a minimal margin, there are going to be very substantial effects on the hospital's operation. That's going to hurt overall competition. It's going to hurt the people of Nampa. It's going to have a significant effect on the public, Your Honor.
Your Honor, I'm going on to another slide, and the rest of them can be seen by this audience.
So St. Luke's may argue, Your Honor, well, this is about Nampa, the hospital market, the facilities markets are Nampa, are Canyon and Ada, so why is that important? Well, it's important for all the reasons I have just shown,

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St. Luke's dominance and TVH's low price and high quality. But it's also important because everybody recognizes that Saltzer, because of its size and its strength, is really important market-wide. Dr. Page says, "St. Luke's is offering a wonderful opportunity to control and codevelop services in Canyon County, because of its importance."

John Kee of St. Luke's said that "It would be very challenging to enter into risk contracting without a foundational group like Saltzer," close quote.

Well, Your Honor, this is a very interesting statement when you unpack it. Risk contracting is what all the providers in the market are moving towards, not uniquely St. Luke's. Saint Al's is doing the same thing, as Mr. Greene mentioned. People all around the country are doing this.

Now, if Saltzer were to be like Primary Health, another large group, independent, Primary Health deals with everybody's networks. They are like Switzerland. And it's to their benefit and it's to the benefit of the public, if you've got a Primary Health doctor, you can join any network and you're going to have them. And if you're Primary Health, if you're in all the networks, you get more business. That allows the networks to freely compete. But if Saltzer is acquired by St. Luke's and pulled out of everybody else's network, how are they going to do risk

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contracting? According to Mr. Kee, it would be very challenging. According to Mr. Billings, as we saw, it would be crippling. So the point is these networks are competing across the market, and Saltzer is very important to them, according to everybody's testimony.

Your Honor, before I go on to this, one other thing I want to add and that is the harm to Saint Alphonsus Nampa here cannot be remedied by entry. And you asked Mr. Greene some questions about entry. And entry is often talked about as entry or expansion of smaller competitors. So one question certainly we're addressing is: Could Saint Alphonsus Medical Group expand and become more of a competitor through entry there? I think it would -- I think even if the answer were yes, the FTC would say that's not enough competition in that market; but, in fact, the answer is no.

The testimony will show Saint Alphonsus Medical Group has tried to recruit pediatricians in Nampa for some years. It's gone zero, zero, zero. It's tried to recruit general internists in Nampa for some years. It's gone zero, zero, zero. Why are those two primary care specialties particularly important, Your Honor? Because Saltzer has got all but one pediatrician in Nampa and all but one general internist. And there are a lot of people who want these kinds of doctors.

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In family practice, the third --

THE COURT: Let me ask a question. Was the reason Saint Al's failed in trying to recruit primary physicians is competition with Saltzer?

MR. ETTINGER: I think, Your Honor, there is a number of reasons you will hear about. Let me summarize them briefly. One is, you know, if doctors are interested in coming to this part of the country, a lot of them prefer Boise to Nampa. And it is more difficult to convince doctors who may have a lot of opportunities to come to Nampa.

Number two, there is kind of a chicken-and-egg problem, and particularly with pediatrics. You can't just recruit one guy, because then he is on call all the time. I don't know if Your Honor is familiar with that. But, you know, "call" among other things, means when the patient calls in the middle of the night and needs somebody, you don't want to be the only guy who gets called every night. So you need partners. So you have got to recruit more than one, really four, to make it attractive to what opportunities are available else where.

Number three, in internal medicine, Your Honor, everybody acknowledges it's very, very difficult today -- didn't used to be true -- very, very difficult today to recruit general internists anywhere. And the reason is

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because they have other things they do. Lots of them become hospitalists, where they work full-time in the hospital. Almost all hospitalists are general internists, and all hospitals today, just about, have hospitalists, people who guide your care in the hospital as a full-time job.

So most internists go towards that or they go on to subspecialize in cardiology or pulmonary or some other field. There is a very small number of graduates in America -- I have heard the number 200, Your Honor -- who graduate every year and go into general internal medicine in an office-based practice. So it's very hard to find those guys anywhere today.

But it's also true, Your Honor, that Saltzer is the popular group, the group with the strong reputation, and so it's harder to compete against that. And that in particular affects the third category, Your Honor: family practice. Saint Al's Medical Group has recruited a few family practice doctors. They had to replace what Mr. Greene referred to as the Mercy Physician Group, when those doctors went to St. Luke's, seven doctors, and they replaced a few of them. But the doctors they brought in are working at about half speed. They can't get enough business.

The reason is the testimony will show, Nancy Powell will testify, is that they are, you know, up against Saltzer. And that's where people want to go. Saltzer has

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a -- doesn't have that problem, you know, because Saltzer gets calls every day from new patients who have heard of Saltzer, their friends use Saltzer, their families use Saltzer, they want a Saltzer doctor, all the Saltzer doctors are full, so they send them to the new guy they just recruited.

So at Saltzer they can ramp up in a much shorter period of time than at SAMG. SAMG has a real problem getting these people busy. Of course, if you recruit them and you're not busy, you're not competing. So it doesn't solve the problem. So that's a quick nutshell on the entry expansion issue, Your Honor.

So just to try to finish up, Your Honor, again, as I said at the beginning, you have got to look at this in the context of all these acquisitions and also, Your Honor, in terms of the acquisitions to come.

Joni Stright is the, I believe, director of physician services. She reports to Mr. Kee at St. Luke's. And she explained that there were several transactions that were in place, and they were put on hold pending the FTC investigation and this litigation. And I asked Ms. Stright, "Are you pursuing other deals?

"No."

"Because of the litigation?"

"Yes."

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So, Your Honor, there haven't been any new deals since this all happened. And so it's about Saltzer, but it's about more than Saltzer, because St. Luke's is ready to continue on the acquisition trail if there is a conclusion that they can lawfully do so. And it's going to get worse in these hospital and surgery facility markets. And it's going to get even worse because it's going to be a domino effect, Your Honor.

The problem is, especially for primary care, is that if St. Luke's keeps recruiting all the primary care doctors, the specialists in this market understand that, Your Honor. They say, if all my referral sources are owned by St. Luke's, I better join the team or I'm not going to get referrals. So it creates a domino effect, and more and more acquisitions occur.

And Dr. Barresi, for example, was asked -- you know, his Boise Surgical Group was acquired -- "Was the group also aware of St. Luke's recent acquisitions of other physician practices:

"Yes."

"Was that a consideration?"

And he said, "Sure. It stands to reason that if we're part of a network, that would facilitate communication and referrals."

So the specialists understand this, and it's going to

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drive other specialists to be acquired and create more problems in these hospital markets.

Dr. Pate wrote an article. He said the same thing. Dr. Pate said in this article, "When a specialist experiences a number of his or her referring physicians being hired by a hospital, this creates pressure for the specialist to consider employment with the hospital to preserve the referral base."

And so that's exactly what we're talking about, what Dr. Barresi was talking about. If St. Luke's can keep acquiring the primary care doctors, Saltzer most notably, that puts pressure on the specialists to be acquired and creates even more dominance. How far is it going to go? Well, Your Honor, this is an intriguing document, interesting question.

Dr. Swanson, the VP of clinical integration, wrote a document which refers to scenario planning and talks about the monopoly model. He sent this document twice, because, apparently, there was a some snafu, to Mr. Billings, the vice president of payer and provider relations. So he apparently wrote it. Mr. Billings apparently got it. We asked each of them in their depositions, "What is this?"

"I can't remember."

"Why did you send it?"

"I can't remember."

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"Did you discuss it?"

"I can't remember."

Mysteriously, neither of these people have the slightest recollection of why they were talking about a monopoly scenario, but, Your Honor, we think we understand why. And we think the evidence shows that that's where we're headed. The antitrust laws don't require that we prove anything like that. But the facts show, Your Honor, that's where we're, ultimately, headed in these hospital markets and other markets if this transaction is not stopped.

Thank you, Your Honor.

THE COURT: Thank you.

Mr. Powers.

MR. DeLANGE: Your Honor, should we open the courtroom?

THE COURT: Mr. Powers, I assume you don't have anything.

MR. POWERS: I don't have anything to --

THE COURT: I mean, I shouldn't say that. I assume you have something.

MR. POWERS: I don't have anything I believe cannot be heard by the public.

THE COURT: Thank you. To avoid disruption, I guess we can wait just a moment to allow whoever wants to

come back in to reenter the courtroom.

****** COURTROOM REOPENED TO THE PUBLIC ******

THE COURT: Mr. Powers, go ahead and proceed.

MR. POWERS: Thank you, Your Honor.

Your Honor, as you know, I represent Treasure Valley Hospital. And there is no competitor, in my view, that is more vulnerable to St. Luke's market power, as you've heard it expressed here today, and will in trial, than Treasure Valley Hospital.

Treasure Valley Hospital is owned, in part, by independent specialist physicians in the Treasure Valley. They're physicians who have had privileges at St. Luke's, Saint Al's, as well as Treasure Valley Hospital. Some of them have privileges at other institutions in the valley. They are physicians who are independent, value independence, and have actually done well in the marketplace as independent physicians.

Treasure Valley Hospital was founded in 1995. It's a relatively small outpatient surgical facility that has four operating suites. It has ten beds. It focuses on outpatient surgery.

You'll find from the evidence, Your Honor, that Saltzer's surgeons -- and we'll refer to them as "Saltzer surgeons," and these are, essentially, surgeons who were part of the Saltzer Medical Group for many years in many

cases -- Saltzer surgeons, who were used to practicing as a group with Saltzer PCPs and other Saltzer specialists, also had an ownership interest in Treasure Valley Hospital. They were, in fact, key surgeons at Treasure Valley Hospital and did a significant percentage of surgeries at Treasure Valley Hospital.

Treasure Valley Hospital, the market for Treasure Valley Hospital that we're examining here in this case is the market for outpatient general and ortho/neurosurgery. You will find that these Saltzer surgeons contributed to the TVH production when it comes to general and orthopedic and neurosurgery. Treasure Valley Hospital, as Mr. Ettinger pointed out to the court in his presentation, is one of the few independent surgery centers in the market and the only one with a market share greater than 20 percent.

Interestingly, the evidence will show that at Treasure Valley Hospital, there is both physician and a high level of patient satisfaction. The patients like the convenience and service that are provided, the patients like the level of attention from the staff, and the patients like the quality of care.

At the same time, you'll find from the evidence that physicians prefer Treasure Valley for certain outpatient surgical procedures. They prefer it because they have more control over the quality of care and service that's provided

to their patients, they appreciate the experienced staff of nursing and surgical assistants, and they perform surgery in a more efficient setting. But most of all, what surgeons at Treasure Valley Hospital like best about Treasure Valley Hospital is they're able to offer lower-cost, high-quality alternatives for care to their patients. That's what they value the most.

Treasure Valley Hospital is known as a high-quality, low-cost competitor. You have heard that a few times. You heard that back in November. You will find from the evidence that TVH is ranked first in the Treasure Valley in many measures of quality and service, even on par with the larger hospitals. Treasure Valley has been recognized nationally for providing quality of care at a low cost. Treasure Valley is a valuable alternative for consumers in the market providing that low-cost, high-quality service.

You will hear evidence that when you compare the cost or the average insurance payments, rather, for certain services at Treasure Valley to St. Luke's, you see large discrepancies in the costs involved. And you see on this chart that we have outlined MRI costs, CT scan costs, colonoscopies, and hernia repairs. The difference in cost is real at Treasure Valley Hospital when it comes to a comparison with St. Luke's.

But the best evidence you're going to hear, Your Honor,

of the low cost and the quality at Treasure Valley Hospital is going to be evidence from Nancy Powell, who when she was the administrator at Saltzer, before this acquisition, sent a memo approved by administration at Saltzer that encouraged all Saltzer employees who are contemplating any sort of outpatient surgery that if it was possible to have their surgery at Treasure Valley Hospital, Saltzer would prefer that those employees of Saltzer choose Treasure Valley Hospital for cost savings, cost savings through their insurance program. To me, that's the most compelling evidence about the value of Treasure Valley Hospital in this marketplace for outpatient surgery.

Treasure Valley Hospital is a competitive constraint to St. Luke's. It's, historically, been a competitive constraint to St. Luke's. And there will be testimony that St. Luke's recognizes that independent surgical facilities, such as TVH, are substantially less expensive and that St. Luke's realizes it needs to reduce its outpatient surgical rates to meet that competition. So Treasure Valley Hospital does affect the manner in which St. Luke's prices its services.

St. Luke's -- as you've heard in both Mr. Ettinger's presentation and in Mr. Greene's presentation -- St. Luke's response to competition has been, rather than competing, to do a number of things, to use a number of strategies. They

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either acquire the competitor, and we have evidence of acquiring of River Street Surgery Center and the acquiring of Boise Orthopedic Clinic, and/or they offer employment to high-producing, independent physicians, and/or they acquire practices. That's been their strategy rather than to compete.

And at Treasure Valley Hospital, Treasure Valley Hospital experienced just that, just the downside of that strategy with respect to St. Luke's purchase of Boise Orthopedic Clinic back in June of 2010. Prior to that acquisition, 2008, 2009, surgeons who were also part of Boise Orthopedic Clinic had ownership interest in Treasure Valley Hospital. They also -- they also provided surgical services and took some of their patients to Treasure Valley Hospital. In 2008, for instance, the Boise surgical cases at Treasure Valley totaled 443. In 2009, 490. Lo and behold, in 2010, on the eve of the acquisition of Boise Orthopedic by St. Luke's, those numbers dropped to 60. And once the acquisition was complete, there were no orthopedic surgeons performing cases at Treasure Valley Hospital. That was an experience, an example that Treasure Valley Hospital had with respect to this acquisition.

And it's what I mean when I say they are the most vulnerable competitor in this marketplace. They, literally, had 10 percent of their surgical volume removed via as a

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result of this acquisition. So Treasure Valley Hospital has experienced this before, they have seen what happens to their organization when these acquisitions occur, and that's why they are parties to this litigation and the Saltzer litigation.

So the strategies in play with respect to the Saltzer deal, as Mr. Ettinger pointed out, were consistent with other strategies that St. Luke's has used. They acquire, they foreclose competition, they demand exclusivity, and they steer referrals. And as Mr. Ettinger told you, the negotiations with Saltzer involve, to some extent, direct negotiations with Saltzer surgeons. And in negotiating with the Saltzer surgeons at first, St. Luke's indicated that they had to divest of their interest in Treasure Valley Hospital, otherwise a deal would not be possible. Interestingly, a vote of all of the physicians at Saltzer rejected that idea, so St. Luke's circled back and suggested to the Saltzer surgeons that if they held on to their TVH interest, they would be penalized via reduced compensation, but, more importantly to these surgeons, as you will hear from the evidence, they would not be allowed to participate in decision-making or participation in the leadership of the organization if they held on to their interest at Treasure Valley Hospital.

Now, these are the same surgeons who like to practice

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at Treasure Valley Hospital because of the high level of control that they have over the environment, over the quality of care for their patients. And St. Luke's, in offering a compromise to them where they would hold on to their interest in Treasure Valley Hospital, wanted to take that sort of control away from these surgeons if they remained with Saltzer and if they continued to practice within the St. Luke's system. That was unacceptable to these Saltzer surgeons.

But the strategies in play were the same, the same that you've heard from Mr. Ettinger. The power of referrals of primary care physicians was in play. And these Saltzer surgeons knew it was in play. They knew what would happen if the primary care physicians were purchased and acquired by St. Luke's. They knew what would happen if they weren't part of that group.

The power of employed specialists to direct surgeries to a facility was also in play. They knew that St. Luke's has an abundance of specialists in orthopedic surgery, in neurosurgery, in spine surgery, and in general surgery who could then step in and direct surgeries to the facility that they -- that they chose. The control of PCPs, the ability to control surgeries was evident to the Saltzer surgeons during these negotiations.

And then, finally, and I think the most important

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point, and a point stressed by Mr. Ettinger at the end of his presentation, is something that is well known to Dr. Pate, something that is well known to Dr. Barresi, and that's the fear of a surgeon losing employed PCP referrals. The fear of a surgeon who sees the doctors who he has had relationships with for years, who trust in the surgeon's quality of care and who the surgeon trusts in their referrals of their patients, they experience the fear of their referrals going to a different organization, and they knew what would happen. They knew and they know that with the PCPs going with St. Luke's, they knew that their referrals would dry up.

This is a slide that Mr. Ettinger already covered. I'll skip over it, Your Honor.

And here is what the impact -- here is what the impact has been on TVH or, rather, on these surgeons as a result of this acquisition.

Dr. Curran in his deposition that was taken in the middle of this year, when asked the question, "What's happened with your referrals from Saltzer physicians?" testified, "They have been reduced by 80 to 90 percent, probably." Dr. Curran is a very robust surgeon, was the primary orthopedic referral surgeon for general orthopedic care at Saltzer.

Dr. Keith Holley, another younger surgeon at Saltzer,

was asked the same question, and his testimony was, "The actual number of new referrals since leaving Saltzer is down 90 percent, I'd say."

Dr. Steve Williams, a general surgeon at Saltzer and a very busy general surgeon at Saltzer, having received the confidence of the primary care physicians who are part of Saltzer to take care of their patients, was asked the same question, and his response was, "Well, I don't really get Saltzer referrals anymore."

All of this testimony has come in in the last several months in the course of this case. And it shows exactly what these surgeons knew when they were feeling that negotiating power and that market power of St. Luke's when the acquisition was being negotiated.

Now, there is a notion, Your Honor, about utilization that you're going to hear in this case, and the notion is that physician-owned hospitals or hospitals that are partially owned by physicians are hospitals that are overutilized. But, in fact, the testimony is that that's not true with respect to Treasure Valley. Mr. Coleman, the medical director of BCI, when posed that question, when confronted with that issue, made a very appropriate response when he said, "We preauthorize our members regardless of where their surgery is being done the same way. So hopefully we would be able to, you know, watch for those

things."

And that comes down to the question of: Is the surgery necessary? Is it required? And I think Mr. Coleman disposes of that notion quite well in his testimony.

So what's the -- what's the harm to TVH if the Saltzer deal stands? Well, the threat of competitive harm is imminent. TVH will be left to survive, to attempt to survive in an unbalanced market where Luke's has a disproportionate share of the market power that can be used at any time to the detriment of TVH. TVH is vulnerable in the marketplace. And really nobody understands that better than St. Luke's.

In Dr. Williams' testimony in this case, he noted that in negotiating with St. Luke's, the Saltzer surgeons heard from Mr. John Kee and from Mr. Taylor, both senior executives at St. Luke's, and in one of those meetings, Mr. Kee said to Dr. Williams, "This is just my opinion, but if I was you, I would sell out your shares while they are still high and get as much as you can from them. And then you can come with us, and you can -- you can be an exclusive partner instead of being a nonexclusive partner."

And Dr. Williams interpreted that comment that -- Dr. Williams said Mr. Kee said that his shares in Treasure Valley would probably be worth half of what they were, in five years.

So the Saltzer surgeons knew when the negotiations were occurring. They knew what the market power of St. Luke's was. They felt the market power of St. Luke's in this negotiation. They valued independence enough. They did not want to be told where to practice and how to practice. And they wanted to maintain their practice at Treasure Valley Hospital. They wanted to give their patients, have the ability to give their patients the alternative and the choice to go to a provider that was lower cost and high quality.

So they rejected. They rejected St. Luke's offer, and they decided to go ahead and maintain their interest in Treasure Valley Hospital so they could provide that alternative.

So TVH faces St. Luke's market power on several fronts in this negotiation. They have had the threat of losing key independent surgeons as shareholders at Treasure Valley Hospital. And that threat was imminent during the negotiations with Saltzer.

Essentially, St. Luke's was striving to convince the Saltzer surgeons to give up their interest in Treasure Valley. But they were able to overcome that. The Saltzer surgeons decided that they weren't going to give in on that issue.

But the market power still remains, and the next front

where they faced market power was on the loss of referrals to those surgeons from Saltzer PCPs, resulting in the reduction of spine surgeries at Treasure Valley Hospital. That's occurred. And they felt the brunt of that, and Treasure Valley Hospital has felt the brunt of that. Treasure Valley Hospital has seen a drop in surgeries, a significant drop in surgeries performed by Saltzer surgeons over the past 12 months.

And on another front, Treasure Valley Hospital -- or on another front, St. Luke's market power has forced the independent surgeons to give up their independence and enter into an agreement with Saint Al's. Now, they forced them to do that, and Saltzer surgeons didn't, necessarily, want to do that, but once they realized that the PCPs were going with St. Luke's, they knew they had no choice but to try to find a place where they could obtain referrals. Because what they knew was going to happen with respect to referrals has, in fact, happened.

And then the other front that TVH faces with respect to St. Luke's market power is the increased concern -- and this is probably the greatest concern, and again, it goes back to Mr. Ettinger's closing remarks, and it goes back to what Dr. Pate knows, and that is the increased concern and fear of all independent physicians who practice at TVH. There are over some 40 specialists that practice at TVH that if

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St. Luke's can control the PCP market, if the Saltzer acquisition is allowed to stand and they can control the PCP market in Nampa, then they can control referrals and they can control these physicians' practice. And all of the present specialists at Treasure Valley Hospital know this, are watching, are watching this litigation, and they have that overriding concern that, in fact, their practices may very well be highjacked in the future.

In the final analysis, Your Honor, the real key here is not what these poor surgeons at Treasure Valley Hospital may or may not be able to do in future years; it's really about what harm there is to consumers. And the real harm to consumers if this deal stands is that TVH will face the real harm that -- I'm sorry, Your Honor -- the harm to consumers is that they won't have the alternative. They won't have the alternative that TVH offers. Their physicians won't have the alternative that TVH offers so that they can go to a -- an institution that provides high quality care at a lower cost when it comes to this particular market.

So that's the real harm, and that's what we're here for, and that's what this case is all about. We firmly believe that TVH is facing the threat of harm, the threat of harm based upon no competition in the marketplace. And we believe that the remedies asked for by both the FTC and by Saint Al's also should be applied as it respects Treasure

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Valley Hospital.

Thank you.

THE COURT: Thank you, Mr. Powers.

Mr. Bierig, let's take a short break, and then we'll proceed to your argument as well as Mr. Julian's. We will try to hold this to about a ten-minute break. I think we got a little longer than that last time. But you do not have any AEO materials during your argument?

MR. BIERIG: That's correct, Your Honor.

THE COURT: Very well. We will be in recess then for ten minutes.

(Recess.)

THE COURT: Mr. Bierig.

MR. BIERIG: Good morning, Your Honor.

Along with my colleagues from Sidley Austin and Walt Sinclair from Stoel Rives, I will be defending St. Luke's at this trial. It is our privilege to represent St. Luke's because the conduct at issue, the affiliation of the Saltzer Medical Group with the St. Luke's Health System, is intended to promote and will promote both competition and the best interests of the people of Idaho.

We believe that the evidence in this case will lead the court to recognize that St. Luke's and Saltzer have entered into this transaction in order to improve the care of patients in this state and to lower the costs of that care,

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and that, if allowed to go forward, the Saltzer transaction will have precisely those effects.

As Your Honor will hear from Dr. David Pate, CEO of St. Luke's, and from several other defense witnesses, the Saltzer transaction is a critical component of St. Luke's ongoing efforts to transform the delivery of healthcare in Southern Idaho in accordance with the Triple Aim that St. Luke's has adopted.

The Triple Aim consists of three pillars: better health, better care, and lower cost. In the furtherance of these three objectives, the transformation of healthcare, which St. Luke's is in the process of achieving, is creating four efficiencies, and I will discuss each of them.

First, community health outreach offering preventive healthcare and education in the community to provide better health, the first of the pillars, for the population so that there will be less need for hospitalization and less need for acute care.

Second, care for all patients, including Medicaid and uninsured patients, regardless of their ability to pay in the interest of both better health and better care.

Third, fully integrated care using the best available electronic health record, evidence -based medicine protocols developed and implemented by physicians, rigorous utilization review and quality control metrics, and

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information on patient outcomes that can come only from an integrated system using very sophisticated measurement tools.

St. Luke's is committed to the proposition that a fully integrated delivery system, as opposed to the current, more fragmented approach that plaintiffs favor, delivers better care at a lower cost through avoiding duplicative tests and diagnostic procedures, minimizing unnecessary or unduly intensive treatment modalities, and generally coordinating the care of the patient.

Fourth, providing better care at a lower cost by transitioning from the current fee-for-service system that pays based on the volume of procedures to an alternative that pays based on the value of the services, a system in which the provider is at economic risk for unnecessary hospitalizations, unnecessary surgical procedures, and unnecessary ancillary services, such as imaging and lab tests.

Taken together, these four features are the result of a new product, a fully integrated healthcare delivery system in which the financial and personal interest of the system is aligned with that of its physicians.

Now, the affiliation of Saltzer with St. Luke's is a key element of St. Luke's efforts to create this new product. At trial, several witnesses will explain why.

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As Your Honor listens to their testimony, I would urge this court to consider whether this is the sort of conduct that the law condemns or should be condemning, or whether St. Luke's should be permitted to proceed in its efforts to move forward to a fully integrated delivery system that is designed to increase quality and lower costs and that will, in fact, produce those results.

For now, however, let me summarize the relevant testimony. It's going to have four principal points.

First, the presence of a core group of physicians who are financially aligned with St. Luke's gives St. Luke's the ability to provide community health programs in Canyon County. Your Honor will hear from Dr. Harold Kunz and other Saltzer physicians about the outreach programs that Saltzer, prior to the affiliation, did not have the time or the resources to undertake to the extent that they are able to do now.

Second, the affiliation will help to fulfill St. Luke's goal of seeing that all patients, including Medicare and Medicaid patients and the uninsured, are cared for. Again, Your Honor will hear the testimony of Saltzer physicians and other physicians that, prior to the affiliation, economic constraints required these physicians to limit the number of low-pay or no-pay patients that they could see.

Third, the affiliation of the Saltzer physicians brings

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into the St. Luke's system a group of primary care physicians who are committed to clinically integrated care using the state-of-the-art electronic health record known as Epic that St. Luke's uses; physicians who are so financially and personally aligned that they have time to develop and will commit to practicing in accordance with evidence-based medicine protocols; physicians who are committed to moving away from the current fee-for-service system that incentivizes overutilization.

Not all physicians are interested in that. Indeed, as you heard, some of the physicians who went over to Saltzer from Treasure Valley didn't want to practice that way, but the physicians that remain are very much in that mindset.

And as several physicians from Saltzer will testify, it was a recognition that they could not provide to their patients the benefits of fully integrated care without the resources and the infrastructure that St. Luke's has to offer that caused Saltzer to want to affiliate with St. Luke's.

And fourth, the affiliation with Saltzer, Your Honor, gives St. Luke's the presence in Canyon County and the scale and the type of financial arrangements with physicians that it needs in order to move to risk-based insurance contracts.

Your Honor will hear from Pat Richards, the CEO of SelectHealth, the Utah-based insurance company with which

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St. Luke's has formed a strategic alliance, how St. Luke's and Saltzer, working together, are moving to provide value-based insurance contracts as an alternative in this market.

Now, you would think -- one would think, Your Honor, that this sort of innovation, both in the market for healthcare delivery and in the market for health insurance, is precisely the sort of conduct that the antitrust laws would seek to promote. After all, as you see on the screen, Your Honor, the antitrust laws are, in the words of the Supreme Court, a consumer welfare prescription. That is what we are trying to achieve through the Saltzer affiliation, consumer welfare.

But in a move that conjures up the title of the book The Antitrust Paradox, the plaintiffs have ironically invoked the antitrust laws in an attempt to undo the extraordinarily procompetitive transaction that is the Saltzer affiliation.

Notably, as we have heard this morning, the two sets of plaintiffs have very different theories. The government plaintiffs allege that the affiliation of so many physicians in the city of Nampa will give St. Luke's the power to raise price above competitive levels.

The hospital plaintiffs say that the affiliation will so dry up referrals to them and will so preclude their

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participation and provider networks, that competition will be suppressed because their ability to compete will be crippled.

Your Honor, we know why Saint Alphonsus and TVH have brought this case. They talk about promoting competition, but they actually fear competition. They fear the competition that St. Luke's is bringing to the market through its transition to fully integrated care and value-based payment.

And they especially fear -- as we heard from Mr. Ettinger, they especially fear the increase in competition that will occur as St. Luke's expands its presence in Canyon County. They particularly fear the possibility of St. Luke's building a hospital in Nampa to compete with Saint Alphonsus Nampa.

Mr. Ettinger's presentation comes down to this: St. Luke's is providing better care in a better way, and that is going to hurt Saint Alphonsus. Well, that is called competition, Your Honor.

We also know why Blue Cross of Idaho, which currently dominates the commercial health insurance market in this state, is supporting the claims of Saint Alphonsus and TVH. Blue Cross will say all the right things about competition. In reality, Blue Cross fears the competition that St. Luke's in part, by virtue of the Saltzer transaction, is in the

process of bringing to the health insurance market through its strategic alliance with SelectHealth that will offer value-based contracts as opposed to the traditional fee-for-service contracts which has made Blue Cross very, very profitable.

The question that the defendants have been asking themselves and the question that the court may be asking itself is this: How can the Federal Trade Commission and the Attorney General of Idaho take the position that a transaction so procompetitive both in intent and in effect violate the antitrust laws?

This morning, Your Honor, I'm going to try to answer that question. And I will do so by identifying and explaining ten mistakes made by the government plaintiffs that have caused them to reach their erroneous conclusions. I will then point out three additional mistakes that underlie the self-serving arguments of the hospital plaintiffs.

I would respectfully ask this court to keep those mistakes in mind as the court hears the evidence that will be brought forth over the next four weeks.

Preliminarily, however, I would like to address the language of the governing statute. Section 7 of the Clayton Act provides that a transaction is unlawful if its effect, quote, may be -- may be substantially to lessen competition.

Plaintiffs would read the words, quote, may be as meaning that they should prevail if there is some possibility of anticompetitive effect from the challenged transaction, no matter how tenuous or no matter how speculative that possibility might be. That is what I understood Mr. Greene to have said this morning.

But the statute requires a considerably greater showing. It requires a plaintiff to prove that weighing the anticipated procompetitive effects against the supposed anticompetitive effects, the transaction is, on balance, likely to cause substantial anticompetitive effects in a properly defined market. Likely to cause substantial anticompetitive effects in a properly defined market.

If the standard were any less demanding, the Eighth Circuit could not have reversed the preliminary injunction in FTC v. Tenet Healthcare Corporation where the district court failed to consider evidence that the merger of two hospitals would produce, quote, better medical care than either of those hospitals could separately because the merged entities could, quote, offer integrated delivery.

Now, Mr. DeLange got up here and said this case is about competition, not about healthcare. But, in fact, as the Tenet Healthcare case makes clear, the efficiencies that come from a healthcare transaction are an integral part of the antitrust analysis, and we believe that the healthcare

and the antitrust laws go hand in hand.

I would submit to Your Honor that the proper methodology for analyzing this case is as follows: First, plaintiffs must make a prima facie showing that the Saltzer transaction will lead to undue concentration in a properly defined market.

Second, if the plaintiffs make this prima facie showing, the burden shifts to St. Luke's and Saltzer to show that the market share statistics inaccurately depict the likely competitive effects of the transaction.

Third, once defendants show the overall likely procompetitive effects, the burden shifts back to the plaintiffs to demonstrate that the procompetitive benefits of the transaction can reasonably be achieved in a manner less restrictive of competition.

I don't believe that the plaintiffs disagree with this framework. However, in applying it, the plaintiffs have, as I noted earlier, made at least ten mistakes. I will now discuss each one of those mistakes.

First, mistake No. 1. Plaintiffs have defined the geographic market far too narrowly. They argue that the geographic market is the city of Nampa. This allegation is hardly surprising because, after the affiliation, St. Luke's will have a substantial percentage of the primary care physicians in that city. But the evidence will show that

the market is broader than the city of Nampa.

Plaintiffs will spend a lot of time eliciting testimony that, all else being equal, people prefer to obtain primary medical care close to where they live or to where they work. We heard Mr. Greene stress that point this morning. Defendants don't dispute that proposition, but that doesn't mean that Nampa is a relevant market. Rather, the relevant market in this case is defined by where people would go for primary medical care if, following the Saltzer affiliation, St. Luke's were to raise prices for the services of Saltzer physicians above competitive levels.

The evidence will show, Your Honor, and life experience teaches that a significant number of people in Nampa, many of whom work in Meridian, Boise, or elsewhere, already get primary medical care outside of Nampa.

Moreover, our expert, David Argue, will explain that if St. Luke's were to raise the prices of the services of the Saltzer physicians above competitive levels, it could not sustain the price increase because people would travel for their care to Caldwell, Meridian, and Boise and would get care from other physicians. Likewise, patients from outside Nampa who currently travel there to get care from Saltzer physicians would cease doing so.

Perhaps most tellingly on this point, we will present evidence of the natural -- of the natural experiment that

took place when Micron excluded Saltzer from its network and thereby required Micron employees to pay more money if they wanted to be seen by Saltzer physicians than other physicians.

As Your Honor will hear, both from witnesses from Saltzer and from Pat Otte of Micron, the result was that Nampa patients left Saltzer in substantial numbers and went to physicians in Caldwell, Meridian, and Boise. This evidence confirms empirically that Nampa is not a properly defined market in which to measure concentration. Plaintiffs' failure to show undue concentration in a properly defined market without more should end this case.

THE COURT: Well, Counsel, even if we expand the market to include all of Canyon County and perhaps even western Ada County, isn't there still a concentration in the order of 65 percent?

MR. BIERIG: I don't think it's quite 65 percent.

THE COURT: I think that's what the plaintiffs suggested.

MR. BIERIG: That's what they suggested. I don't think it's quite that high. Certainly, if we expand the market, Your Honor, to go beyond Nampa to include Meridian and Boise, there will still be a market concentration issue, but it will be significantly less than if we were dealing with Nampa.

But that actually brings me to my second point, so here it comes. Plaintiffs place too much reliance on the Herfindahl-Hirschman analysis, which measures market concentration. As the D.C. circuit pointed out in the Baker Hughes case, which we cite in our briefs, market concentration statistics alone are insufficient to determine the outcome of a Section 7 case.

In the words of that court, quote, evidence of market concentration simply provides a convenient starting point for a broader inquiry into future competitiveness.

I want to stress that, Your Honor. "Evidence of market concentration simply provides a starting point for a broader inquiry into future competitiveness."

I would note, by the way, that the panel that decided the Baker Hughes case includes two current justices of the U.S. Supreme Court.

Reliance on HHI figures is particularly inappropriate in a relatively small market in which two strong competitors are vigorously competing. Take, for example, a market in which Home Depot and Lowe's are competing and one of them acquires a smaller retailer. No matter what the HHI figures might say, one can be sure that there will continue to be intense competition as long as Home Depot and Lowe's remain rivals.

The same is true here. The same is true of St. Luke's

and Saint Alphonsus. These systems are strong and vigorous competitors. As long as St. Luke's and Saint Alphonsus are competing, as surely they will, the court need not worry about anticompetitive pricing.

Indeed, Your Honor will learn that Saint Alphonsus' own internal documents and vision is that the market for healthcare in the Treasure Valley will be characterized by intense and vigorous competition between two large integrated delivery systems: St. Luke's and Saint Alphonsus.

THE COURT: But if the merger substantially weakens one of those two strong competitors, should that be something the antitrust laws should be concerned with under the Clayton Act?

MR. BIERIG: If the acquisition were to weaken the other competitor to the point that it cannot be an effective competitor, yes.

THE COURT: I guess that's the point, is --

MR. BIERIG: But it's not that if they just lose some referrals or have some other issue, that's -- the antitrust laws don't concern themselves about that. The antitrust laws require that they have to demonstrate that they are so weakened, that they can't effectively compete.

And I'll get to that in one of my other mistakes, Your Honor -- hopefully not my mistakes, but one of the mistakes that the plaintiffs make.

Mistake No. 3: Plaintiffs overlook the fact that the Saltzer affiliation is largely a vertical transaction. St. Luke's is a healthcare system while Saltzer is a group of physicians that is one component of such a system. Thus, this litigation is not like a case involving a horizontal merger of two competing banks, like the Philadelphia National Bank case that Mr. Greene cited, or even two competing hospitals, which are the cases on which the plaintiffs rely.

Notably, every one of the market power slides that Mr. Greene put up this morning addresses a purely horizontal merger, not an affiliation between an integrated delivery system and a group of physicians.

The courts have been considerably more receptive to vertical transactions because they realize that such transactions are far more likely to produce efficiencies. And at trial, we will demonstrate that the Saltzer transaction will produce all of the four efficiencies that I spoke about earlier.

Now, I don't want to overstate our case. I acknowledge that there are some horizontal aspects to the Saltzer transaction, and St. Luke's does, in fact, employ physicians. But given that St. Luke's is an integrated delivery system, the Saltzer transaction is properly viewed as primarily vertical. And the integration of the Saltzer

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physicians into the St. Luke's health system will produce enormous benefits for better health, better care, and lower costs.

By the way, Your Honor has referred to it as a merger. I don't use the word "merger" because "merger" tends to suggest horizontality. This is much of an affiliation that is vertical.

Mistake No. 4: Plaintiffs give inadequate weight to the fact that the purpose of the Saltzer transaction is to promote access and quality and to reduce costs.

In this connection, I would invoke the words of Justice Brandeis in Chicago Board of Trade v. United States that I cited at the preliminary injunction hearing, words that are as true today as when they were written nearly a century ago and when I quoted them in this courtroom nearly a year ago.

"The history of the restraint, the evil believed to exist, the reason for adopting the particular remedy, the purpose or end sought to be attained are all relevant facts. That is not because a good intention will save an otherwise objectionable regulation or the reverse, but because knowledge of intent may help the court to interpret facts and to predict consequences."

Your Honor, I have been in a lot of antitrust cases, and I can tell the court that when a transaction has anticompetitive effects, the underlying documents are full

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of references to anticompetitive purpose.

In this case, in the literally millions of pages of documents that have been produced, there is not a single St. Luke's document to the effect that the purpose of the Saltzer transaction was to raise price above competitive levels.

Plaintiffs will, of course, cherry-pick and distort isolated statements from various documents, usually not St. Luke's documents, to try to advance their case, as we have already seen this morning. But the court will see, from numerous documents that we will present at trial, that the fundamental purpose of the Saltzer transaction was to achieve the goals of the Triple Aim. This is a classic case of the dog that did not bark. We will not be seeing barking about efforts to raise price or to dominate the market.

Beyond -- beyond the documents, Your Honor will hear from several Saltzer physicians, including its president, Dr. John Kaiser, that Saltzer's purpose in affiliating with St. Luke's was: One, to permit it to provide even better care to its patients; two, to gain the benefits of a sophisticated electronic health record and other systems that Saltzer could not afford and could not gain access to on its own; three, to enhance Saltzer's ability to reach out to the community; and, four, to free itself from the economic constraints that forced it to limit the number of

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no-pay and low-pay patients that it could see.

Your Honor will also hear from St. Luke's witnesses, such as Chris Roth, the CEO of St. Luke's Treasure Valley, and John Kee, a senior St. Luke's executive with decades of healthcare experience in Idaho. They will testify as to the intent of the Saltzer affiliation and what St. Luke's hopes to achieve.

As the court listens to their testimony, I believe Your Honor will have little doubt that, from St. Luke's perspective, the Saltzer transaction had but one purpose: to take care forward by producing the four efficiencies that I mentioned earlier.

As Justice Brandeis foretold, knowledge of the pro-patient, pro-consumer intent of the parties to the Saltzer transaction should help this court in interpreting the relevant facts and in appreciating the procompetitive effects of the transaction.

That brings me to mistake No. 5: Plaintiffs fail to recognize the need for a substantial group of fully aligned physicians in order to realize the benefits of a fully integrated delivery system and to transition to value-based payment.

The traditional antitrust model, Your Honor, was to have a lot of atomistic providers competing against one another. But contemporary antitrust laws have recognized

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that large groups of physicians must practice together and must be financially aligned in order to achieve the efficiencies of coordinated 21st-century care.

Thus, nearly 20 years ago, in Blue Cross v. Marshfield Clinic, the Seventh Circuit rejected an effort under the antitrust laws to break up the Marshfield Clinic, even though that clinic employed all the physicians in Marshfield, Wisconsin, and even though it employed all the physicians in several other towns.

As Judge Posner wrote, "We live in the age of technology and specialization in medical services. Physicians practice in groups, in alliances, in networks, utilizing expensive equipment and support. Twelve physicians competing in a county would be competing to provide horse-and-buggy medicine. Only as part of a large and sophisticated medical enterprise such as the Marshfield Clinic can they practice medicine in rural Wisconsin."

THE COURT: Counsel, where do you draw the line, however? If that rationale were to apply to every case, then that would mean that all mergers, all acquisitions are good, and any failure to merge or any failure to acquire is bad because it does not allow us to bring those -- I'll use the word economies of scale -- to provide better healthcare. Surely, that cannot be --

MR. BIERIG: It clearly cannot be the case that

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there will be only one system. We need to have competition. Where we draw the line is whether there is another system in there competing forcefully against the system that is putting together the networks.

THE COURT: So your vision, then, would be that if, indeed, you have a community in which there are at least two vibrant, strong competitors, if one competitor needs to reach a certain -- I'll use the word level of concentration or -- what's the term you've used? -- a substantial group of physicians in order to obtain a fully integrated system, that acquisitions that may consolidate practice groups into one unit should essentially be hands off from the antitrust laws because it is necessary, in the words, I guess, of Judge Posner, to take us out of the horse-and-buggy age of medicine and to bring these kind of economies of scale to bear upon the problem.

MR. BIERIG: That would not exactly be my position. There is something to -- there is some aspects to that.

THE COURT: My point is as long as -- but as long as there is a vibrant competitor using fee-for-services, then we shouldn't be concerned about concentrations achieved by its competitor if they are designed and intended to obtain integrated healthcare.

MR. BIERIG: That is correct. But the way

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Your Honor put it would take it out from the antitrust laws. The antitrust laws would, of course, apply. We're not out from under the antitrust laws.

THE COURT: What you're saying is --

MR. BIERIG: But we believe the antitrust laws are satisfied.

THE COURT: The procompetitive benefits outweigh whatever anti- --

MR. BIERIG: That is exactly what we are saying, and we believe that --

THE COURT: All right.

MR. BIERIG: -- Saint Alphonsus documents reflect that. They say that what the future holds for the Treasure Valley is intense competition between these two systems. They have their own system, which is a very effective, very excellent system. And we are competing with that. We have a different approach.

We believe more strongly than they do in the importance of full and tight both financial and personal integration and alignment, but there will be these two strong competitive forces in this market. And we believe that as long as we have that, in addition to such third entities like Treasure Valley Hospital and some of the other smaller entities, we don't think that we have to fear anticompetitive conduct. And we think, as Your Honor put it

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exactly correctly in our view, that the procompetitive benefits of putting together this fully integrated system vastly outweigh any threat to competition. We don't think there is going to be any anticompetitive conduct as long as we have this very vigorous competition.

THE COURT: Well, I think Mr. Greene -- I asked him whether or not in his view -- and, of course, he disagreed with that proposition -- that you could only obtain integrated healthcare through consolidation of the type that's involved here. And he indicated that in many instances, fairly small entities are able to obtain that type of healthcare system and without running into the problems that at least the government and the plaintiffs here argue that you're running into with the Clayton Act.

You disagree, I assume, that, indeed, you have to have these kind of consolidation or grouping of physicians?

MR. BIERIG: These tightly aligned relationships? Yes, we feel that way very strongly. We believe the evidence will show, Your Honor, that the systems that have been most successful in controlling costs and improving quality, if you look at the Mayo Clinic, Intermountain Health in Utah, if you look at Geisinger Clinic, Kaiser, you will see that all of them have very tightly aligned physicians financially.

But, more than that, we don't think -- you will hear me

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say this later, but we don't think that the court has to make that judgment. The market will make that judgment. We have a vision as to -- as to what the best way of competing is. It's through setting up this fully integrated system.

Saint Alphonsus has a somewhat different vision, and that is competition. The market will decide which of us is right and who succeeds. The court doesn't have to decide today which is the right way, as Mr. Greene has invited this court to do. It's enough to say that our vision has a substantial basis and we think is going to lead to all sorts of benefits, just as Saint Alphonsus thinks that its approach will lead to all sorts of benefits, and then the market will decide who is right.

So, to continue, Your Honor, in the nearly 20 years since Marshfield Clinic was decided, the need to practice medicine in sophisticated enterprises that align, both personally and financially, PCPs, medical specialists, hospitals, and other caregivers to coordinate care and thereby to provide better care at lower costs have only increased.

Likewise, the cost and the complexity of the resources and the infrastructure to achieve these goals have only skyrocketed. Indeed, the financial incentives offered in the accountable care organization and the Medicare shared savings program provisions of the Affordable Care Act

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demonstrate that the United States Congress has recognized this reality.

At trial, Your Honor, we will prove that the challenged transaction is necessary to enable the Saltzer physicians to practice medicine in Canyon County most effectively and to position St. Luke's to most efficiently implement the transformation of healthcare delivery in the Treasure Valley from the current fee-for-service model to a value-based model.

You will hear from Dr. Kaiser, the president of Saltzer, and from other Saltzer witnesses that Saltzer approached St. Luke's. St. Luke's did not approach Saltzer. Saltzer approached St. Luke's for what became the challenged transaction only after Saltzer concluded, after much deliberation, that as an independent clinic, it could not afford the tools needed to practice 21st century medicine, could not compete for risk-based contracts, and could not effectively compete in other ways.

To paraphrase the Seventh Circuit, only as part of a large and sophisticated integrated delivery system such as St. Luke's can Saltzer physicians practice medicine most effectively in Canyon County.

And, conversely, from St. Luke's witnesses, the court will hear about St. Luke's vision for taking care forward in Canyon County.

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As I mentioned earlier, the Saltzer physicians bring to St. Luke's a group of physicians who share St. Luke's own vision. Further, the scale that comes with a large group of closely aligned physicians will facilitate St. Luke's transition to value-based contracting. And absent this sort of group, contrary to what Mr. Greene may think, St. Luke's cannot afford to take the risks inherent in value-based, risk-based contracting.

This brings me to mistake No. 6: Plaintiffs improperly dismiss the procompetitive benefits of the Saltzer transaction because it will take time for the full benefits of that transaction to manifest.

According to plaintiffs, the defendants bear a, quote, heavy burden, quote -- and continuing the quote, to verify by reasonable means the likelihood and magnitude -- the likelihood and magnitude of each asserted efficiency, how and when each would be achieved and any costs of doing so, how each would enhance the merged firm's ability and incentive to compete, and why each would be merger-specific.

That statement is, of course, an impossible burden to meet; and for that reason, it is not the law.

Rather, as the D.C. circuit held in the Baker Hughes case, evidence on a variety of factors can rebut a prima facie case. And as we know from Tenet Healthcare Corporation, that evidence includes proof that the

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transaction will lead to integrated delivery of care and ultimately to better care.

Significantly, contrary to what the government plaintiffs say, that proof does not require a degree of clairvoyance alien to Section 7 which deals with probabilities, not certainties. Those are not my words. Those are the words of the D.C. circuit.

Section 7 does not require a degree of clairvoyance alien to that section, which deals with probabilities, not certainties. And that is particularly true in a case like this, Your Honor, where the full benefits of the transaction will take time to manifest.

At trial, we will show that the first two objectives of the Saltzer transaction -- community health outreach and provision of care regardless of ability to pay -- are already occurring.

But we will also show that the full benefits of coordinated care will not be realized until the Saltzer physicians are put on the Epic electronic health record, which, as Your Honor will recall, we committed at the preliminary injunction hearing not to do. They will not occur until the best medical practice protocols have been developed and are implemented. And they will not fully occur until the outcomes of various alternative approaches to diagnosis and treatment have been measured and studied

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through the WhiteCloud system which the court will hear about at trial.

Likewise, the transition from volume-based to value-based payment will take time while the payment structure of physicians is realigned and payers become more comfortable with that approach.

Now, plaintiffs, we expect at trial, will make much of the fact that the compensation of the Saltzer physicians is tied to the amount of patient care they provide. That line of argument overlooks the fact that the -- that the transition to value-based healthcare delivery takes time.

In this connection, Your Honor will hear testimony that St. Luke's is in the process of changing the compensation of cardiologists, pulmonologists, and internists, so that a substantial portion of their pay is now based on quality rather than on quantity considerations. Your Honor will also hear that the ability to implement that kind of change and the journey from volume-based to value-based compensation of physicians depends on the ability to capture and track clinical data and outcome on a very tight -- and on a very tight relationship between physicians and the St. Luke's system.

Plans are underway to modify the compensation of Saltzer physicians to base their compensation more on quality considerations and less on volume considerations.

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As I said, for the reasons that will be presented at trial, those changes will not occur overnight.

Plaintiffs dismiss the efficiencies because they have not yet materialized. Mr. Greene this morning talked about Epic and WhiteCloud but dismissed them because they have not yet been proven quantitatively. They cannot possibly have been proven quantitatively at this point, but that fact does not detract from the fact that these systems, the investment that St. Luke's is making, will bring about advances in the quality of care and reductions in the cost of that care.

The law does not require that all the benefits of a transaction as complex as this one be proven with specificity at the outset of the transaction. The law does not require that the procompetitive, propatient benefits of the transaction be nipped in the bud because they have not fully flowered at the time of trial and cannot be quantified at the time of trial. It is enough that those benefits are likely.

Thus, the Ninth Circuit in Miller v. California Pacific Medical Center cautioned against undoing a healthcare merger where doing so might, quote, detract from the quality of care for patients and might mean that, quote, innovative procedures made possible by the merger would have to be abandoned.

That is exactly what the government plaintiffs are

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asking this court to do, is asking the court to order abandonment of this affiliation with the effect that the quality of care will be detracted from and that innovative procedures will be nipped in the bud.

At trial we will show that there is more than enough evidence to allow the Saltzer transaction to go forward so that the people of Southern Idaho can reap its current benefits and can look forward to the even greater benefits to come.

This brings me to mistake No. 7: Plaintiffs give inadequate weight to the significant constraints on anticompetitive price increases that they theorize from the Saltzer transaction.

Plaintiffs simply ignore the fact that St. Luke's is an Idaho-based charitable institution dedicated to enhancing the welfare of the people of Southern Idaho. We will show through the testimony of several key St. Luke's executives and through the testimony of board member Skip Oppenheimer that St. Luke's is committed to keeping the price of healthcare down.

Indeed, the third pillar of the Triple Aim, the aim that animates St. Luke's, is lower cost. And we will show that the St. Luke's board includes several representatives of employers who have a material interest in keeping their employees' healthcare costs low.

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In this connection, I would call Your Honor's attention to the discussion in FTC v. Butterworth Healthcare Corporation. There, the court found that "The involvement of prominent community and business leaders on the boards of these hospitals can be expected to bring real accountability to price structuring."

Now, needless to say, I'm not going to stand up here and say that the board members control the pricing or set the prices, but they do set a tone for management. And if the board learns that St. Luke's is pricing in a way that is inconsistent with the Triple Aim or with the mission of St. Luke's, it can and will take action.

But, quite apart from the Triple Aim, Your Honor, the presence of strong purchasers such as Blue Cross of Idaho constrains any ability to raise price above competitive levels.

And here I want to go back to the analogy that I made earlier to the market that includes Home Depot and Lowe's. There is a critical difference between this case and the cases that are relied upon by plaintiffs, and that's shown by that analogy. Those retailers sell to individual shoppers who have absolutely no bargaining power.

St. Luke's, by contrast, negotiates with sophisticated and powerful insurance companies that control a substantial percentage of the covered lives in this area. These

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purchasers will strongly push back against almost any price increase that St. Luke's might seek, let alone anticompetitive price increases, which St. Luke's has no intent to seek.

And that goes further to the question that Your Honor asked when you said -- when the court said: So what's the limiting principle? We would be more worried about having competition among two systems if the payers were these atomistic, sort of helpless groups that had no countervailing power. Here, by contrast, as long as we have Blue Cross of Idaho and Regence and other very strong payers, including strong payers like some of the employers, I think we have even less to fear about anticompetitive price increases.

Mistake No. 8: Plaintiffs' evidence of past pricing comes largely from the Magic Valley with different demographics and facts and includes no analysis supporting the conclusion that any price increases were above competitive levels.

We expect, Your Honor, that plaintiffs will try to prove a likelihood of anticompetitive price increases from the Saltzer transaction by citing evidence from various past transactions. However, many of those transactions took place in the Magic Valley, a market with demographics and other facts very different from the Treasure Valley. This

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fact alone makes the relevance of that sort of evidence highly questionable, at best.

In any event, proof of price increases without more does not establish anticompetitive conduct. As we discussed in our motion for partial summary judgment, prices increase for a variety of legitimate reasons. It is, therefore, quite telling that, despite presenting two different economic experts, plaintiffs will offer no economic analysis demonstrating that any prior transaction involving St. Luke's has resulted in prices above competitive levels.

Mistake No. 9: Plaintiffs wrongly discount the procompetitive benefits of the Saltzer transaction.

Plaintiffs dismissed the asserted benefits of the Saltzer transaction as speculative. But we will prove, through the testimony of Professor Enthoven, that these benefits have actually occurred in systems such as Mayo Clinic, Geisinger Clinic, and Kaiser, systems that St. Luke's is seeking to emulate.

And, in fact, if Your Honor reads in the healthcare journals, you will see that it's not only Mayo, Geisinger, and Kaiser; but, as I said earlier, if one looks at the most successful systems, they are precisely the kind of system that St. Luke's is trying to achieve here in the Treasure Valley.

Your Honor will also hear from a number of physicians

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who have affiliated with St. Luke's in the past. These physicians will tell the court how their affiliation with St. Luke's has improved the care that they provide to their patients and how it has enabled them to offer more outreach programs and how it has enabled them to treat all patients regardless of the ability of those patients to pay.

These benefits may not be precisely quantifiable, as Mr. Greene would like us to do, but they are hardly speculative. In this connection, I would note that Your Honor will hear from Dr. Pate and Mr. Kee that transforming the delivery of healthcare is a very difficult process that takes time. Yet, St. Luke's has made massive strides in only a few short years.

It has invested tens of millions of dollars to convert its clinics, which operated dozens of electronic medical records that didn't communicate with one another, to one common EHR, the gold-standard Epic program. And the notion that I heard from plaintiffs' counsel, well, Saltzer and some of these other groups had eClinicalWorks, so they already had an electronic health record, it's just nonsense. Sure, there are other electronic health records, but they don't do nearly what the Epic system does in terms of trying to achieve the goals we're talking about of clinically integrated care and helping to identify best practices and reduce duplication.

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St. Luke's has also invested millions more in the WhiteCloud system, which will enable it to extract and analyze data from medical records so that robust information on the quality and cost of care provided by its clinics, including Saltzer, can be harvested, analyzed, and used by physicians to change practice patterns in interest of patients.

Now, plaintiffs say St. Luke's will make Epic available to independent practitioners through some pilot program. Well, we have thought about that kind of program, but the general consensus is that it will be very hard to do, and most independent practices will not want to pay the cost that it takes to be involved with that.

Once again, the value of these tools in improving the quality of care and in transitioning to value-based healthcare delivery cannot be quantified with precision. But these benefits are not speculative in any way, and the law does not require us to somehow quantify their benefits, especially when those benefits have not yet been achieved.

Mistake No. 10.

THE COURT: Counsel, let me ask you to step back for a moment on that last point. At what point -- I mean, what is the burden, I guess, upon the defendant to show that the projected benefits which have not yet been achieved are, in fact, not just pie-in-the-sky hopes but, in fact, we know

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it has occurred?

Now, you have mentioned the Mayo group, Intermountain Healthcare, and some others that have, in fact, achieved that. But is it universal? I mean, has there always been procompetitive benefits from this? Any downside? And if it is that clear-cut, why isn't the entire country moving that direction with some speed?

MR. BIERIG: Well, the entire country is moving in that direction with different degrees of speed. But if you look at the Affordable Care Act, you will see that they're trying to incentivize these accountable care organizations, which are, in effect, on the Medicare level what we are trying to achieve across the population of Southern Idaho.

The reason it hasn't been done more is these things are tremendously costly. They require a great deal of work. You have to change all sorts of mindsets. You have a lot of physicians who don't want to be told how to practice medicine, what kind of protocols to follow. You have some people who want to maximize their revenue by independent practice, such as the physicians who went over to Saint Alphonsus from Saltzer.

There is lots of impediments to this kind of thing, but I think there is a general consensus that the way to increase quality and reduce costs is to have these fully integrated systems.

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Now, that's not to say that there haven't been fully integrated systems that have failed. Sure, there is always failure. There are issues. But, in general, the approach that St. Luke's is taking is in line with all of the best thinking in healthcare.

Are we going to succeed? We feel quite strongly that we will. That doesn't make it a certainty. But what we're saying is that the antitrust laws should not nip our efforts in the bud before we have a fair chance to show what we can do.

THE COURT: In any event, there is enough of a track record that it is not just pie in the sky?

MR. BIERIG: This is so not pie in the sky. This is -- this is not even pie. This is reality right down here on planet earth.

And you will hear from Professor Enthoven and you will hear from physicians who have become part of the St. Luke's system as to the benefits that will come and that are coming. And it's -- as I said, it's not only the benefits of having the integrated delivery system. It's also the ability to provide care to Medicaid patients, to Medicare patients, to the uninsured, none of which is happening. I'll get to that in a minute.

But let me go to mistake No. 10, Your Honor. Plaintiffs fail to appreciate that the benefits that

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St. Luke's is seeking to achieve in the Saltzer transaction cannot be achieved as effectively through a looser affiliation with Saltzer. We have talked already about this, Your Honor, so I will try to be brief.

But our witnesses will explain why tight financial and personal alignment of physicians is the best way to realize the benefits of fully integrated care and to move to value-based payment.

Of course, independent physicians play an important role in St. Luke's strategy, as they do in all of these other systems. However, we will show that a substantial nucleus of tightly-aligned physicians has been proven to be necessary to achieve the kinds of objectives that St. Luke's is trying to achieve.

Now, as Your Honor has heard already, the court is going to hear a lot of argument from plaintiffs seeking to persuade Your Honor that a looser affiliation with an independent physician is better than the tighter affiliation that St. Luke's believes to be essential.

Notably, other than the ipse dixit from plaintiffs' counsel, plaintiffs are not going to have any in-depth analysis to support this conclusion. And, in fact, all the empirical data is to the contrary. But, more importantly, this case is not about whether it is more effective to employ physicians or to work with independent physicians or

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how tightly to align them.

Both St. Luke's and Saint Alphonsus employ hundreds of physicians. The difference between the two systems is one of degrees, as we have spoken about.

Saint Alphonsus and its co-plaintiffs are asking this court to unwind the Saltzer transaction because they assert that their model is less restrictive but likely to achieve the same benefits that St. Luke's is seeking to achieve. As I just said, there is no proof of that in this case, and the experience of institutions such as Mayo, Intermountain, and many others is directly to the contrary.

But the more fundamental point, which I have already stated to Your Honor, is that the court doesn't have to determine which approach is better. The market will sort that out. And if St. Luke's is wrong, it will lose in the competitive process.

And here, I would like to invoke two very thoughtful authority. First, Judge Frank Easterbrook, a noted antitrust scholar, pointed out in an article entitled "The Limits of Antitrust" that "This is precisely the sort of situation in which the court should stay its hand. The market will self-correct any anticompetitive effects, whereas a judge erroneously prohibiting behavior with real procompetitive potential could create significant and long-term social costs," so says Judge Easterbrook.

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But Judge Easterbrook's views are not binding on this court, so let me turn to what the Ninth Circuit has to say.

The Ninth Circuit makes a very important point on the importance of judicial restraint in a case such as this one. In a case called United States v. Syufy Enterprises, the court said that if market forces can potentially cure the perceived problem, then a court, quote, ought to exercise extreme caution because judicial intervention in a competitive situation can, itself, upset the balance of market forces, bringing about the very ills the antitrust laws were meant to prevent.

We believe that if Your Honor were to enjoin this affiliation, the court would in effect be doing exactly what the Ninth Circuit has cautioned against, intervening in a competitive situation, which will upset the balance of market forces and bring about the very anticompetitive ills that the antitrust laws were meant to prevent.

So, Your Honor, we would respectfully request that the court consider these ten mistakes in plaintiffs' case as the evidence is brought forward in the next four weeks. We submit that as the court hears that evidence in light of these ten mistakes, Your Honor will conclude that judgment should be entered against plaintiffs on their pricing claims.

Now I would like to turn to the claims of the hospital

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plaintiffs. But at the outset, before getting into the specifics, it's worth recalling the words of the Areeda and Hovenkamp treatise. Because a competitor opposes efficient aggressive and legitimate competition by its rivals -- and that is exactly what we're seeing here -- it has an incentive to use an antitrust suit -- which is also what we're seeing here -- to delay their operations or to induce them to moderate their competition, which is, again, what they have succeeded in doing because we haven't been able to integrate Saltzer.

For that reason, the courts are properly skeptical of many rivals' suits, particularly when the practices are not obviously exclusionary, so say Professor Areeda and Professor Hovenkamp.

Perhaps recognizing this lawsuit is nowhere near the rare case in which a transaction can be successfully challenged by a competitor, the hospital plaintiffs advance a line of argument based on alleged exclusionary conduct, which argument involves three additional mistakes.

It's noteworthy, in my view, that the government plaintiffs explicitly state in their pretrial brief that they, quote, do not join, end quote, the hospital plaintiffs in the hospital plaintiffs' argument.

So mistake No. 11: The hospital plaintiffs falsely imply that some loss of referrals from the Saltzer

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physicians amounts to a violation of the antitrust laws.

In fact, the antitrust laws do not concern themselves with harm to competitors. They prohibit harm to competition. Loss of referrals or exclusion from networks can violate the antitrust laws only if they foreclose the competitor plaintiffs from competing in the relevant market.

Here, this court will not hear a shred of evidence to the effect that, by virtue of the Saltzer transaction, Saint Alphonsus or TVH will cease to be effective competitors. Sure, they would like to have more referrals from Saltzer physicians; sure, they would like to, you know, be in every network they can be. But there is nothing in this record that will show that Saint Alphonsus or Treasure Valley Hospital will cease to be effective competitors.

Let me just say a couple words about each of those two entities. Saint Alphonsus is part of a huge national chain that is highly capitalized and has tremendous resources to bring into this market. Treasure Valley Hospital is owned by physicians who have every financial incentive to refer patients to that hospital. They make a tremendous profit.

I had to chuckle when I heard Mr. Powers talk about the poor TVH physicians. I think everyone in this courtroom would like to have the balance sheet of those poor TVH physicians.

But in terms -- also to note, Mr. Powers made a big

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point about they are a lower cost provider. Let's talk a little bit about the reasons for the lower cost. They take the least risky procedures. They do only outpatient work. They take very little Medicaid, much less than either Saint Alphonsus or St. Luke's. And this is very important: They don't have an emergency room. They don't operate an emergency room. They don't take any kind of care that comes to an emergency room. So no wonder their costs are so low. So I think that's worth pointing out.

But in any event, the court will hear evidence -- I should also say in that, that it's noteworthy that Congress in the Affordable Care Act passed a law forbidding the building of any more physician-owned specialty hospitals along the lines of TVH.

To the contrary, Your Honor, the court will hear evidence that Saint Alphonsus and TVH are investing heavily in Canyon County. They are both -- notwithstanding their talk about they have lost some referrals from Saltzer physicians or they are concerned about this or that, they are both fully busy and active and strong competitors. Their plans to invest heavily in Canyon County are not the actions of competitors who believe that they will no longer be able to compete. What it does explain is why Saint Alphonsus and TVH are trying so hard to have the Saltzer transaction undone.

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That brings me to mistake No. 12. The hospital plaintiffs erroneously suggest that they will lose so many referrals and other opportunities, that their ability to compete, that their ability to be effective competitors in the market will be comprised.

Quite to the contrary, the defendants will demonstrate at trial: One, there is absolutely no policy against referrals to Saint Al's or TVH; two, St. Luke's does not incentivize physicians not to refer to these institutions.

And, by the way, Mr. Ettinger could not be more wrong when he says that the contract with Saltzer incentivizes the physicians to refer away from Saint Al's or from TVH. There is nothing of that in the contract. And contrary to what he says, they do not get paid for sending ancillary services to St. Luke's or anyone affiliated with St. Luke's. I don't know where he got that, but he is just dead wrong about that.

Three, it was a key consideration for the Saltzer physicians that they be free to refer in the best interests of their patients; and, four, Saltzer physicians have continuing and are continuing to make referrals, substantial numbers of referrals, to physicians affiliated with Saint Alphonsus and TVH.

So let me talk a little bit about the network issue. I really, again, kind of was interested in Mr. Ettinger's

slide about referrals. The slide he put up there was: What if Saint Al's kicks Saltzer out of its network? I don't know if the court noticed that. But the slide was not talking about St. Luke's; the slide was talking about Saint Alphonsus kicking Saltzer out of its networks.

As to networks, the evidence will show that there is intense competition. And Mr. Ettinger's parade of situations in which St. Luke's determined not to bid all arose in the context of fee-for-service contracts where, as we have already said, what St. Luke's is interested in is trying to develop these risk-based, value-based contracts, and he overlooks the fact that that is a fundamental part of St. Luke's strategy.

The fact is, as I said, there is intense competition. There will continue to be intense competition. St. Luke's has its own network. Saint Alphonsus has its own network. There are broad networks that consist of many providers, and I don't think we need to worry about that kind of competition.

And finally, the third -- the 13th mistake, the third one that is exclusive to the hospital plaintiffs, is that they rely on evidence from past transactions that have absolutely no probative value on the referral issue.

The hospital plaintiffs will seek to introduce evidence based on purported changes in hospital admissions by

surgical practices that have been acquired by St. Luke's. In fact, the evidence will show that, to the extent that admissions went down, it was often because primary care physicians at Saint Alphonsus stopped referring patients to the acquired practices or for other reasons, such as actions by TVH that were unrelated to the conduct of St. Luke's.

In any event, the evidence will show that as far as Saint Alphonsus' lost admissions from the surgeons whose practices were acquired by St. Luke's, Saint Alphonsus made up for that loss by having other surgeons affiliated with Saint Alphonsus do the work.

Saint Alphonsus and TVH are not in any way threatened as competitors. Sure, they don't like the competition, but they are not in any way threatened as competitors.

Now, the hospital plaintiffs will also rely on a study by one of its experts that purports to show a drop-off in admissions to Saint Alphonsus by primary care physicians who became associated with St. Luke's.

In fact, the evidence will demonstrate that those physicians continued to send patients for admission to Saint Alphonsus. However, because the admitting physician was formally listed on the document reviewed by the expert as a Saint Alphonsus hospitalist, it appeared to her that admissions had dropped off significantly. In fact, admissions did not significantly drop off, as the physicians

in question will testify.

The artifact caused by the fact that the admitting physician is listed as a Saint Alphonsus hospitalist completely undercuts reliance by the hospital plaintiffs on the study.

THE COURT: What about the anecdotal evidence, the documents put up by either Mr. Greene or Mr. Ettinger or Mr. Powers, which suggested that there was an understanding prior to some of these prior acquisitions that, in fact, the referrals pattern would change and that the referrals would come, if not exclusively, largely to St. Luke's?

Again, I don't have them in front of me, but was that just a misunderstanding about what --

MR. BIERIG: I think that's a misunderstanding. But, more importantly -- I think that's wrong. But, more importantly, what we're dealing with here is not these past transactions in the Magic Valley. We are dealing with the Saltzer transaction.

THE COURT: I thought some of those had to do with, like, with the Boise Orthopedic Group.

MR. BIERIG: Yes. You will hear from the Boise Orthopedic Group, and you will find out, Your Honor, that there was no understanding along those lines whatsoever.

THE COURT: Okay.

MR. BIERIG: But, more importantly, in the Saltzer

transaction, there was an understanding. And the understanding is the exact opposite of what plaintiffs would have the court believe. The understanding would be that the Saltzer physicians would be free to refer and to admit wherever -- to refer to whatever physician and to admit to whatever facility they deem to be in the best interests of their patients.

That was an article of faith with the -- with the Saltzer physicians, and it was one that St. Luke's readily agreed to because St. Luke's is interested in, to go back to the Triple Aim, better care. If the Saltzer physicians believe that their patients are best served at Saint Alphonsus Nampa or by having a surgeon from TVH or a surgeon from Saint Alphonsus do surgery or some specialist do the work, it was critical for -- for Saltzer that they be able to do that, and St. Luke's was in full agreement with that approach.

So, whatever the case may have been with Boise Orthopedic -- and Your Honor will hear from a representative of that group -- the fact could not be more clear that Saltzer has retained the ability and will retain the ability to refer wherever it deems to be in the best interest of the patients. St. Luke's supports that, and the facts support it. The facts support it. If you look at the actual referral patterns, you will see that St. Luke's is

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continuing to make substantial referrals to Saint Alphonsus-Nampa and to physicians who are associated with the hospital plaintiffs.

So, in short, Your Honor, the evidence will show that, when judged against the very high standard that the hospital plaintiffs must meet, the claim of unlawful exclusionary conduct by virtue of the Saltzer transaction is not even close to one of the cases described by Professor Areeda and Hovenkamp. What it is is an attempt to forestall and foreclose the competition that St. Luke's is bringing to Canyon County. Accordingly, we would respectfully ask this court to enter judgment against the hospital plaintiffs on their claims.

Now, finally, even though we believe strongly that there has been absolutely no violation of law, I feel compelled to say a few words about the remedy proposed by plaintiffs. And I would like to start out by citing not a 1960 case, you know, over 50 years old -- although I, myself, have cited one that's a hundred years old. But I would like to start out with another -- a decision by another district court in this circuit.

As the Central District of California put it, "Divestiture should not be entered into without substantial evidence that the benefit outweighs the harm."

Here, the evidence will demonstrate that quite the

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opposite is true. Any benefit of divestiture -- and we see none -- will be far outweighed by the harm that that remedy would cause.

To begin, far from injecting competition into the market, the most likely result of divestiture is dissolution of Saltzer. Certainly, Saltzer will not be an effective competitive force.

Your Honor will hear testimony from Bill Savage, CEO of Saltzer, and from Saltzer physicians about the loss of seven surgeons who left Saltzer to join Saint Alphonsus. These surgeons were Saltzer's greatest revenue producers. Their departure has so crippled Saltzer financially, that, if divested, Saltzer is unlikely to survive very long and will certainly not be a strong competitive force.

The plaintiffs, you know, they seem to think they know what's going to happen, but I would submit that Mr. Savage, the CEO of Saltzer, knows better than they do. But beyond -- beyond Mr. Savage, his testimony will be corroborated and enhanced by the analysis performed by defendants' expert Lisa Ahern.

Ms. Ahern will show that, as a result of the departure of the surgeons and the loss of other physicians, if Saltzer is divested, the Saltzer physicians will be at income levels at approximately of only two-thirds of where they were prior to the affiliation. In the circumstances, it seems quite

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fair to conclude that the most likely outcome of divestiture would be the breakup of Saltzer and possibly the departure of some of the Saltzer physicians from the Nampa area. You will hear a lot of testimony on that, Your Honor.

On the other hand, Saltzer physicians will testify that divestiture will eliminate their access to the infrastructure that they need to offer their patients the fully integrated 21st century medicine that those patients deserve and that affiliation with St. Luke's permits them to have.

The Saltzer physicians will explain how they will not be able to implement community health outreach programs nearly as effectively as they would as part of St. Luke's. They will further explain how they will not be able to treat all Medicaid and other low-paying patients. Thus, not only frustrating their own view of what they, as physicians, would like to do, but frustrating the objective of the Department of Health and Welfare of this state to see that quality care be provided to all such patients.

And we will provide evidence that divestiture will dramatically slow the efforts of St. Luke's to move to value-based payment, efforts which are also very much supported by the Department of Health and Welfare of the State of Idaho.

Third, divestiture is entirely unnecessary even if the

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court were somehow to find that the Saltzer transaction is unlawful. Any concern about higher prices through the exercise of a market power can be remedied by an order requiring that fee-for-service contracts be negotiated by Saltzer, which remains a distinct entity independent of St. Luke's.

Indeed, St. Luke's offered this approach, both to the Federal Trade Commission and to the State of Idaho, even before the government plaintiffs filed suit. And the Federal Trade Commission, itself, has imposed a similar remedy in the Northwest Hospital case and recently accepted a similar remedy in the Phoebe Putney case.

Your Honor, at the end of the day, this case raises the question of whether a midsize market such as the Treasure Valley can realize the benefits of the clinically integrated care that Congress in the Affordable Care Act sought to incentivize and that the best thinkers in health policy believe to be our society's greatest hope for reducing cost while increasing quality.

The inescapable fact, as demonstrated by these numerous systems that we have talked about and that is beginning to be demonstrated by St. Luke's, itself, is that creation of a fully integrated delivery system on a scale necessary to permit transformation from volume-based to value-based payment requires close financial and personal alignment with

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a large number of primary care physicians.
On the facts of this case, if the court were to find the Saltzer transaction unlawful, Your Honor would be sending a signal across America that wooden application of HHI numbers and recitation of speculative competitive harm will relegate the people in such smaller markets to what the Seventh Circuit has termed "horse-and-buggy medicine."
That, Your Honor, we submit, would be absolutely the wrong signal to send. Preempting innovation in healthcare in this way is not consistent with, much less required by, the antitrust laws. This court should not erect a judicial barrier to innovation in healthcare here in Southern Idaho and as a precedent throughout this nation. We would respectfully submit, Your Honor, that after all the evidence is in, this court should enter judgment for defendants on all claims.
Thank you.
THE COURT: Thank you.
Mr. Julian.
MR. JULIAN: May it please the court and counsel. I wish to offer just a few brief comments as my opening statement. I am Brian Julian. I represent Saltzer Medical Group. With me is Dr. John Kaiser. At various times, we may see Bill Savage. Dr. Kaiser is the president of the group; Bill is the CEO.

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I realize this case is important to all parties. I think, as my friend Ray Powers stated the other day, there are still obviously primary and secondary parties. Saltzer finds itself aligned with St. Luke's Health System with a common defense and a shared need to present this case in an efficient manner under the clock.
I can represent to the court that we have discussed major and significant issues with St. Luke's counsel. We have reached consensus. Thus, if it appears Saltzer is not asking as many questions or not calling as many witnesses, we are doing that out of the economics and efficiency required to present this in a timely fashion.
I am very much aware of the characteristics of the physicians of Saltzer Medical Group. I have represented them for probably 20 years. Simply put, Saltzer Medical Group opposes the claims made by the government that somehow Saltzer is reducing competition and impairing medical care, when the short of the matter is to be nothing could be further from the truth.
Further, the remedy sought by the government plaintiffs against Saltzer would cause great harm to this clinic and the respective medical care provided.
Effectively, I represent a doctor's office. This doctor's office has changed over the last couple years. It has lost about a dozen doctors. The top producers have

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quit, gone to work for Saint Al's, which now maintains a significant presence for orthopedic surgery in Nampa.
Our point in the defense is that the government, when administering a utilitarian law, and the court, in applying the law, should do what a good physician does every day of his or her life. First, do no harm. Do no harm to the ultimate consumer. Do no harm to the good quality of medical practice in the community. And do no harm to physicians who have chosen to make integration of medical services a valued tool for properly serving their patients with their chosen partner, St. Luke's Health System.
You will hear from a number of the Saltzer doctors. Dr. John Kaiser, who is here, is the president of the group and presents an interesting perspective and background. He holds a bachelor's degree in electrical engineering, has a master's degree in industrial engineering, was in a career with IBM for many years. He also acquired his master's in business administration before going on to medical school and becoming a board-certified obstetrician/gynecologist. He was also a shareholder for Treasure Valley Hospital.
So his perspective on business survival and business plans is of a distinctive quality. He, along with other physicians, will testify that, due to market conditions, it became obvious that a standalone medical clinic that charges fees for services could no longer survive in the current

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medical climate.
Affiliation with another group was absolutely essential. It was essential for economic survival as well as simply recruitment for replacement of retiring or terminating physicians. Such affiliation is not only a trend, but it appears to be highly encouraged under the Affordable Care Act and under Medicare regulations, which strongly promote consolidation and the efficiencies that go with such a business model.
Of course, St. Luke's was receptive to the idea when approached by Saltzer. You will hear that the concept of affiliation was first considered as much as seven or eight years ago. It is interesting that Saint Al's, one of the plaintiffs in this matter, also made an offer to affiliate the services with Saltzer.
After approximately three years of deliberation, consideration, and negotiations, Saltzer selected St. Luke's Health System and rejected Saint Al's. Prior history with Saint Al's was a significant factor in coming to this decision.
Of course, if the group would have gone with Saint Al's, that entity would have had a larger market share than the current affiliation with St. Luke's under the plaintiffs' definition of market.
What you will also hear transcending even the

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economic -- economics of consolidation was the physicians' desire to improve medical care. You will hear that physicians are excited about advanced electronic medical record system. And while Saltzer did have its own electronic medical record system, the Epic system offered by St. Luke's is of a considerable higher quality with much greater capability. It is the gold standard.

In fact, the evidence will show that Saltzer actually tried to purchase the Epic system but was told by Epic it could not purchase it because they weren't big enough to have it.

In addition, St. Luke's Health System integrates Epic with WhiteCloud, and it's an additional software tool. WhiteCloud now provides Saltzer physicians with quality control, statistical guidelines in the treatment of their individual patients. For example, Dr. Kunz and Dr. Kaiser will testify how this program has served as a remarkable advance in improving medical care.

Testimony will also show that Saltzer physicians are enthusiastic about access to these tools and increasing the level of care for their patients that would simply not have been available without this affiliation. They want to have the highest medical care. They believe their patients deserve the kind of care that they experience at Mayo Clinic, at the Cleveland Clinic. And this gives them that

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opportunity.

Another great benefit which the physicians support is the ability to treat any patient regardless of their ability to pay or with whom they are insured. All of the government-insured patients, whether it be Medicare, Medicaid, TRICARE, even the uninsured, will be accepted. And a physician is going to be paid regardless of insurance status.

It should be remembered the purpose of antitrust law is to enhance consumer welfare. In Canyon County, there is a growing Medicaid population. A significant benefit has happened to those consumers. No longer are they waiting in a public medical clinic for services. They are allowed to go to the best clinic in the county, maybe the best clinic in Idaho, for medical care. Physicians no longer have to screen their patients on ability to pay. They are able to render medical treatment to all patients regardless of their insurance status.

How can this significant and growing population just be ignored when we speak of enhancing consumer welfare? Physicians will testify that to limit the geographical area only to Nampa is unrealistic. Many patients travel to Meridian or where they work in Boise for medical care and vice versa.

The Saltzer integration with St. Luke's Health System

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will have no negative effect on the availability of or costs of medical services for the Nampa/Canyon County residents. There is no threat of any inappropriate leverage from St. Luke's and Saltzer negotiating with payers. Such projections are based upon pure speculation.

Lastly, the evidence will show that if this transaction were to be unwound, the survival of Saltzer Medical Group is in question. For example, the testimony will show that the doctors would have to assume massive amounts of overhead due to the leaving, the absence of other producing physicians. Working the same hours, same patient loads, they can expect approximately a one-third decrease in their pretransaction pay due to the increased overhead. Medicare, Medicaid patients would have to be restricted.

At the time, Saltzer would have to -- at that same time, they would have to try to recruit new physicians without any hospital assistance, no economic incentives. And it simply would be an act of futility.

With Saint Al's taking the top-producing physicians, Saltzer can't sustain itself. The resources of Saltzer will be so depleted and the prospect of rehabilitation so remote, that Saltzer will face the grave probability of business failure. It's likely this will lead to doctors finding more lucrative deals, other cities in Idaho, perhaps in other states. How can that be said to better the consumer welfare

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in Nampa?

Based on this, we believe plaintiffs' claims must fail. Saltzer stands uniformly with St. Luke's in support of this transaction. Thank you.

THE COURT: Thank you, Mr. Julian.

Counsel, we only have one hour before the end of the day. Let's take one more ten-minute break, and we'll try to hold this to ten minutes. Let's try to reconvene at 20 minutes to. We will then have 50 minutes for our first witness, which I assume the plaintiff will have teed up and ready to call. We'll be in recess for ten minutes.

MR. GREENE: Your Honor, if I may.

THE COURT: Mr. Greene.

MR. GREENE: I'm so sorry. The first witness plaintiffs will call will be Mr. Crouch. We believe this is one of the witnesses for which the courtroom may need to be closed. So you may want to --

THE COURT: If counsel is in agreement -- I should have checked the order. If that's the case, we'll have to clear the courtroom while Mr. Crouch is testifying again. And then as soon as -- well, will that take the balance of the morning -- of the day?

MR. GREENE: Yes, and carry over until tomorrow I think, Your Honor.

THE COURT: So, with that understanding, then,

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just to make it easier on the audience, then we won't allow anyone else back into the courtroom for the balance of the hearing today.

We'll be in recess.

(Recess.)

****** COURTROOM CLOSED TO THE PUBLIC ******

THE COURT: The plaintiffs may call their first witness.

MR. STEIN: Your Honor?

THE COURT: Yes.

MR. STEIN: I'm sorry. Scott Stein. Before we begin, I just wanted to flag one issue. We anticipate that Mr. Crouch's testimony is going to cover a number of the subjects that have been the subject of some of the pending motions in limine and even the briefing that was done last week concerning the Magic Valley and the surgery center issue. And I'm sensitive to the fact that we don't want to keep popping up every time these issues come up. Your Honor may want to hear some testimony on it before ruling on it. We would just look for some direction from the court as to how to handle that so we preserve our objections.

THE COURT: Well, I think one way we've, normally, or that I have often addressed that is just allow one party to have a continuing objection based upon a previously filed motion in limine. I think, by and large, the court, as I

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most commonly do, feel that it's very difficult to resolve those kinds of issues without hearing the evidence in context.

With regard to the Magic Valley issue, in particular, I thought it would be necessary to really have the context and understand what the differences are and what the parties' arguments are. I think if it's adequate for your purposes, I could simply note that you have a continuing objection to any question regarding the Magic Valley transaction, of course subject to the court's final ruling, perhaps as part of its final decision or during the course of the trial that it either is or is not admissible. Is that adequate?

MR. STEIN: I think so, Your Honor. Thank you.

THE COURT: All right. Then you have a continuing objection to any testimony concerning the Magic Valley transaction.

All right. Mr. Greene.

MR. GREENE: Thank you, Your Honor. Plaintiffs call Jeffrey Crouch.

THE COURT: Mr. Crouch.

Mr. Crouch, would you please step before the clerk, be sworn as a witness, and then follow Ms. Gearhart's directions from there.

JEFF THOMAS CROUCH,

having been first duly sworn to tell the whole truth,

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testified as follows:

THE CLERK: Please take a seat in the witness stand.

MR. GREENE: Your Honor, I do have a small binder of documents I would like Mr. Crouch to have with him at the witness stand.

THE COURT: Yes. Mr. Metcalf, could you help us out.

THE CLERK: Please state your complete name and spell your name for the record.

THE WITNESS: Jeff Thomas Crouch, C-R-O-U-C-H.

THE COURT: You may inquire.

DIRECT EXAMINATION

BY MR. GREENE:

Q. Good afternoon, Mr. Crouch. Let's start with just a few moments about who you are. Could you please describe your education after high school.

A. Undergraduate work at Brigham Young University with a major in finance. Then right after that graduation, that would have been 1985, went to the University of California at Los Angeles in their school of public health. Earned a master's degree in public health. That degree is the -- in their school that's their focus on hospital and health services management.

Q. So this would be closer to a program that would be

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equivalent of a master's in business administration?

A. Yes, but with a specific focus on the healthcare industry.

Q. Okay. And Mr. Crouch, can you briefly describe your work history since you graduated from UCLA.

A. Right after UCLA worked for Ernst & Whinney, which at that time was a large consulting firm. I think they're one of the big -- at the time big four accounting firms. That was in downtown Los Angeles. My activities were in revenue management for hospitals, bonds for hospitals to raise money, and process re engineering for business offices within hospitals.

After Ernst & Whinney, I was there a couple of years. I joined up with Humana, which at that time was a hospital company. They owned hospitals across the country. And I worked in two of their facilities in Orange County for the next three or four years.

I, at that point, decided to leave the hospital side of the industry and enter into the health plan side and took a position with PacifiCare Health Systems. That would have been around 1992 in their corporate office in Cypress, California. I was there for a couple of years, was asked to take on the director of finance role for a new acquisition that they just concluded, which was California Dental Health Plan. That was the largest capitated dental plan in

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California. I was there. That was a turnaround period. I was there for a couple of years and was asked to go do the same sort of turnaround sort of activity in Seattle, where I took on responsibility for the third-party administrator office in Seattle and was in Seattle with PacifiCare until about 2001. And I could see that Humana was or, rather, United Healthcare was about ready to acquire PacifiCare, so I left there and joined Blue Cross of Idaho here in Boise.

Q. And what was your position with Blue Cross?

A. I joined as a director of provider contracting, ended up becoming the vice president of provider contracting as a promotion about three or four years later and have been in that vice president role since around 2006.

Q. What, in general terms, is that role, Mr. Crouch?

A. My area manages all of the relationships with all of the providers in Idaho. There are about 9,000 providers in Idaho. We develop all the contract terms. We handle all of the recruitment and contract activity for those providers. We service their needs after the contract has been signed. Any need that can't be managed through our regular customer service line comes to my team.

Q. And what is a provider for purposes of this discussion?

A. Anyone who is delivering healthcare services, so that would range from physical therapy, pharmacy, to

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hospitals and physician services.

Q. And do you personally get involved in at least some negotiations?

A. Yes. I'm personally involved with any of the very high-dollar negotiations.

Q. And can you give some examples of those sorts of high-dollar negotiations?

A. The seven or eight largest hospitals in the state we would consider to be high-dollar. They are all hospitals that would be $10 million or more annually per contract, so I would be involved in those. Most of those activities, that would be back office involvement with review and policy establishment for the very highest hospitals -- which would be St. Luke's, Saint Al's, Eastern Idaho Regional Medical Center, Portneuf, and Kootenai -- I would be personally involved during the negotiation.

Q. And, approximately, how large are those contracts?

A. Those contracts are in the $30 million range on the low end to REDACTED for St. Luke's.

Q. And do you have a staff that assists you in this work?

A. I have a staff of 72: 10 of them are provider contracting folks; 10 or 12 are data analyst folks; provider relations; fraud, waste, and abuse; and some other activities, as well.

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Q. What do your data analysts do for you?

A. They prepare all the material as part of the contract negotiations. Some of the staff manage the fee schedules that we use to compensate providers for services rendered, ad hoc reporting, provider directory activities, things along those lines.

Q. Okay. I would like to take you back, briefly, to your prior experience, because earlier in the day in a portion of this proceeding in which you were not present, we were talking a bit about risk-based contracting and, specifically, risk-based contracting in California. Do you have any experience with risk-based contracting in California?

A. Yes. As I mentioned, I was the director of finance for California Dental Health Plan, which was the largest capitated medical -- or dental plan in California.

Q. And what is a capitated plan?

A. Literally, per head, so under a capitation arrangement, an insurance company will compensate a provider organization a fixed amount per person, and that's a capitated fee. That amount varies based on the level of risk that the provider is taking on and based upon the acuity of the membership in that risk. And so the capitation amount is a transfer of risk from the health plan to the provider.

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Q. So can you describe in lay terms what is the risk that the provider entering into such a contract takes?

A. It can vary pretty widely. In the dental world, as an example, there are very few catastrophic services, so the capitation would transfer the risk for bite film X-rays, for repair of cavities, for root canals, for replacement of crowns, that sort of thing, all the way up to -- when I was in the corporate office at PacifiCare and when I was in Seattle, we would capitate provider organizations, so commonly physician groups, for different levels of risk that would be on the low side primary care services and on the high side primary care specialty care and hospital services in their town.

Q. And do you have perspective on the -- this would be for physician services and, preferably, primary care physician services. Is there -- what's the smallest contract you've seen that is risk-based that's with physicians?

A. So I'm going to define "risk" here, probably a term that needs a little bit of definition.

Q. Please.

A. When I'm talking about risk, I'm talking about a contract that will have the provider's payment level vary based upon the outcome of the services that were delivered that year or that month.

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So the providers at risk, their payment would be higher or lower based upon the performance of the membership in their group. We have a network or a risk arrangement in Boise as small as two physicians. It's Initial Point Medical Group. And from that two physicians on the low side, it would go up to many hundreds of physicians for the large systems.

THE COURT: Can I ask you to explain what you meant by having the provider's payment level vary based upon the outcome of the services? So could you just give me a more concrete example of how that would work, either, I guess, in the California dental or the two-physician-based, risk-based plan you have identified here in Boise?

THE WITNESS: Yeah. So I can give you -- use some real-world numbers. On a commercial health plan here in Idaho, you and I and people in the room here would be in what would be commercial. That's a non-Medicare and non-Medicaid insurance product. The average premium for a member in such a product is going to be about $300. So we call that the total basket for services that could, potentially, be transferred out through a capitation arrangement to a medical group.

The portion of that that's primary care is going to be about 30, 30 to 33 percent, so that would be 90-ish dollars would be for primary care services -- or for physician

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services. 50 percent of that amount is going to be for hospital services. So that would be $150 or so. And then the balance would be pharmacy and whatnot.

So when we're establishing a capitation arrangement, one of the questions we're establishing is how much of that $300 -- excuse me -- total budget is the provider group going to be accountable for. And then we put corridors around that because a group the size of, say, Initial Point, which is two providers, they don't have the capital capacity to go at risk for catastrophic services. So we would put a corridor of risk around their performance.

THE COURT: Something akin to like a large deductible?

THE WITNESS: Yeah, although it doesn't -- it doesn't play out quite that way. So more likely what we would do is we would go to -- so real-world example, another one, a product that we're putting in the marketplace right now is a product that takes that $300, and we would go to the provider and say we need to get you to give us a discount. Your risk is going to be to the degree of the discount you're offering up front. So they might say we'll give you a 5 percent discount. We build that discount into our premium so that $300 now becomes a lower dollar amount. They are not at risk for anything less than the 5 percent discount they had before, and then they can participate in a

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surplus if there is a surplus in the pool above the $300 level.

THE COURT: But they would participate in a risk for the nonprimary care portion as well?

THE WITNESS: Yeah.

THE COURT: So that they have an incentive to reduce unintended -- you can slide your chair up.

THE WITNESS: No, I was bumping the arm here so --

THE COURT: Is that more comfortable for you?

THE WITNESS: Good now, yeah.

THE COURT: All right. So that's what would provide an incentive for the provider to sort out ways to provide the same healthcare in a less expensive but still effective fashion so that they can profit from that and reduce the risk of actually requiring hospitalization for more expensive types of care. Is that the concept?

THE WITNESS: Right. And as you mentioned, we would like them to have as part of that incentive arrangement the whole package of healthcare services so that they are interested in hospital services and outpatient surgeries in addition to just professional services.

THE COURT: All right. I'm sorry. Go ahead, Mr. Greene.

MR. GREENE: That's fine.

BY MR. GREENE:

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Q. I would like to get a sense of how Idaho compares to other states with respect to risk-based contracting. How prevalent or common is risk-based contracting in the Idaho market?

A. It is -- it is not common. The three different types of products which are commonly sold in a commercial marketplace are traditional products. A traditional product would be where the member has -- just shares a coinsurance. So we would provide 80 percent coverage, and the member would pay 20 percent of the bill. That would be a traditional policy.

PPO policy, which has more elements of member cost-sharing, some benefit to the member if they go to a physician office visit, as an example.

Both traditional and PPO products are not capitated products. They are not risk-sharing products.

And then HMO-style products would be managed care, and Idaho has not been accepting of HMO-style products ever. They really developed in the '80s, and there has never been a strong market for HMO products in Idaho.

Q. What briefly defines an HMO product, from your perspective?

A. At point of enrollment, the member pulls from a provider directory the provider they want to associate with. That provider -- so in my case then I would pick the name of

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a provider, and I would -- say I picked Dr. Jones, that is now my primary care provider. And I need to go to Dr. Jones' office in order to have access to any services through the benefit.

Q. And why is it that risk-based contracting is so closely associated with HMO products as distinct from the PPO and traditional products?

A. Well, the assignment of members is necessary in order to have these risk pools work. So in a PPO, let's say that you're in Boise, there is St. Luke's, Saint Al's, Primary Health, a variety of other providers. We can't attribute the portion of a member's claim that would be -- so we wouldn't be able to give St. Luke's, as an example, here is the list of the members in your pool because the members haven't selected anyone. And quite commonly, we'll see a member will go to a St. Luke's primary care doc, they will go to a Primary Health urgent care center, and they will deliver their baby at Saint Al's. And so they are getting services from many of the providers in the community.

Q. And is that an ordinary expectation of consumers in the Idaho market?

A. That is one of the defining elements of a PPO or a traditional product is that they can go seek services from any provider in the directory.

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Q. Now, how does the Idaho situation compare with, say, the situation in California?

MR. STEIN: Objection, Your Honor, lack of foundation. I believe Mr. Crouch testified he has been in Idaho and not any other state for the last 12 years.

THE COURT: Well, Mr. Greene, perhaps, we can lay a foundation how the witness knows. I'm going to assume there is a number of different ways that --

BY MR. GREENE:

Q. Mr. Crouch, how do you know about risk-based contracting in other areas?

A. Well, the Affordable Care Act in front of us, there has been a large volume of publications around the nature of markets across the country. And California and Minnesota, a number of markets are represented as being still highly penetrated for managed care.

Q. Okay. And do you have any direct professional experience with respect to those kinds of products in the California market?

A. Sure. I was involved in those products when I was working for PacifiCare and when I was working in the Humana hospital systems.

Q. And to the extent of your knowledge, roughly, what is the percentage of risk-based contracting as a percentage of providers in California?

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MR. STEIN: Your Honor, same objections.

MR. GREENE: He has provided a basis on his reading and research. I think that's more than sufficient, Your Honor.

THE COURT: I'm going to allow it, Counsel. Objection is overruled.

THE WITNESS: As I recall -- so the HMO style, people picking an HMO product in California, it's 20 to 30 percent of the market is managed care.

BY MR. GREENE:

Q. Okay. Do you have knowledge of this Washington market, Washington state market?

A. I have not read anything recently about Washington State, so I don't have detailed knowledge.

Q. Okay. Now, what are the advantages of a risk-based contract to a payer like yourself?

A. A risk-based contract is a better alignment of financial incentives within the system. So if you look at -- you know, look at the U.S. healthcare and compare it to any other nation in the world, we're at least double the next nation in terms of cost and triple and four times the amount commonly for other nations in the world.

And one of the elements that's believed to be driving that high cost is the mechanism that we use to reimburse services, which is we pay fee-for-service for

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services in the U.S. healthcare system. So in very simple terms, that incentivizes volume. It does not incentivize value. So the volume of it -- so a physician in our network then has an incentive to perform -- the more services they perform, the more they can bill and the more they're compensated.

Q. And are there any disadvantages associated with risk-based contracts either to the provider or to the payer?

A. Well, there would be an inherent concern that services would be underutilized, so there are mechanisms put in place to make sure that that doesn't occur. If you had a provider physician or a provider system who was trying to maximize their income, they could maximize that income at the detriment of their patients. Outside of those detriments, these financial arrangements that align those incentives I think are beneficial.

Q. Okay. And are there different types of risk-based contracts?

A. Sure. That's a pretty broad category. You could have a risk-based contract which -- where the provider says I'll take a discount up front, and let's get together and measure the services performed during the year, and at the end of the year, if there is a surplus or a deficit, we'll each participate in that surplus or deficit.

So that would be an early stage of a risk-based

contract for a provider that's trying to transition into it, all the way to capitation, full capitation, where the provider system would take -- they would say they would take $250 per member per month for any member in our product, and we transfer that risk and that premium to them, and then they would be at full risk for those services.

Q. Okay. And what would -- from your perspective, what would be a comfortable size in terms of number of doctors in a group that might be able to reasonably provide services under a risk-based contracting scheme?

A. Well, as I mentioned a little bit earlier, we have a risk-based arrangement, which is two physicians, and, in fact, those two physicians commonly outperform the rest of the network. We don't know exactly why that's happening, but we suspect part of the reason is because they are very focused on they know it's just the two of them. They know all the membership in their network, and they are very focused on making sure that they are managing appropriately within the network.

But in that case we would not pass on catastrophic risk to the group because they could have a very damaging financial result if they had a large oncology case or some traumatic experience happen to one of their members. So the protections need to be in place to prevent that.

Q. And are you aware of the size of the Saltzer

Medical Group, approximately?

A. Medical groups change. People come and go. I think it's 45 to 50 physicians, as I recall.

Q. Do you think, theoretically, Saltzer Medical Group could enter into risk-based contracts?

A. They have been in risk-based contracts with us for as long as I have been in the plan.

Q. What are the -- could you please describe the risk-based contracts.

A. We have the one area in Idaho that is accepting of what we would call managed care risk-based services is Medicare Advantage, and there's a bunch of reasons for that. One of the reasons is because the member is making an individual selection rather than an employer having to make a selection for their employees. So Saltzer has been in our Medicare Advantage risk pool for back into the 1990s, I believe.

Q. And are you familiar with the size of St. Luke's healthcare system?

A. Something on the order of 500 to 600 physicians. I have not pulled that number recently.

Q. And is there any reason, from your perspective, why St. Luke's healthcare system couldn't engage in risk-based contracting today?

A. They're a participant in risk-based contracting.

They have our most aggressive version of risk-based contracting in Idaho. They have a -- we signed a contract with them just in January to transfer more risk to them.

Q. From your perspective, do they need additional physicians in order to engage in additional risk-based contracting?

MR. STEIN: Objection, lack of foundation.

THE COURT: I'm going to overrule the objection. You may answer.

THE WITNESS: The scale of St. Luke's and Saint Al's and Kootenai, all of our large hospitals, they have got sufficient scale to engage in risk-based contracting when it's small numbers. You don't need to have a large number of physicians to engage -- we manage the level of risk proportionate to the level of the provider organization.

I think there is -- I think there is a dispute in the marketplace about what you need to have risk-based contracting. One of the questions would be do you need to own the practice or can -- is a clinical affiliation appropriate? I think we have seen both examples work fine.

BY MR. GREENE:

Q. And both the independent physician model and the employed physician model seem to work with respect to risk-based contracting?

A. Yes. In North Idaho, the North Idaho Health

Network is a network of nonemployed physicians. They have been -- I think we consider them the most active in terms of integrating their clinical activities, far more active than what we see here in the Treasure Valley. They are not employees of each other.

Q. And can you briefly describe the activities that they have engaged in that you think is so special?

A. They have a contract -- you know, part of it is you need a -- you need a clinical organization that allows the doctors to get together and establish what their program's going to look like to create a dynamic and a culture for what their organization is going to look like. And then they need to actually spend the time talking about what are our protocols, what are we going to support in terms of efficient utilization of care, in terms of quality improvement programs. It's just the hard work of getting together and making the program work I think is what differentiates the systems. The ownership is not what differentiates success in the system.

Q. Okay. And can you briefly describe what successes they have had in terms of clinical integration.

A. So clinical integration can have a specific legal meaning, and I'm not trying to represent that they have met or haven't met whatever that legal --

Q. I'm sorry. In the lay sense, what positive

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outcomes has this group had?

A. Well, that is the one area of Idaho that has been accepting of some level of managed care programs. And so in North Idaho we have had commercial managed care products that have been active in the market, still have them active in the market even to this day, although to a smaller extent than in other states. But part of that is because the North Idaho Health Network has developed a level of integration within their community and their system so that the employers and that marketplace are willing to buy their product.

Q. Okay. Now, how does risk-based contracting compare to value-based contracting? Are those similar terms or different terms?

A. I guess I would define -- they are similar in some way. Value has got maybe a broader connotation. I don't know how you would -- maybe there is a question at play there. Probably wasn't -- that may have come up earlier, I'm guessing. I don't know how you define value other than delivering a product that's either lower cost or higher quality. So when we talk about value as a health plan, those are the two components we would identify as being the variables within the value equation as the price goes lower or the quality is improved.

Q. Okay. And have you ever sought to negotiate a

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risk-based contract with BCI that they did not want to enter into, ultimately?

A. We're talking about NIHN or North Idaho Health Network?

Q. I'm so sorry. St. Luke's.

THE COURT: Would you rephrase the question?

MR. GREENE: Sure.

BY MR. GREENE:

Q. Are you aware of any risk-based contracts that St. Luke's refused to enter into with BCI?

A. If you look at the payment system on a scale, it's not a yes or no, and it's not just one choice or a second choice. So if you look at it on a scale, the left side of the scale is going to be fee-for-service payments. Physician sees a patient, they bill us a code, we pay them the fee for that code, and then that goes on as services rendered.

There are a whole series of risk-based arrangements that can occur prior to capitation for a population of members. One of them is bundled payments. And we have been, as a health plan, interested in implementing a bundled payment program for many, many years. St. Luke's is the first organization that we approached for a bundled payment program, and they declined to participate and have continued to decline.

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We have had a great deal of success with a bundled payment with one of the other hospital systems, though, so we continue to try to pursue that avenue, and that's not been met with any success.

Q. And what is a bundled payment program? What does that mean for us laypersons?

A. If you take an episode of services. I'll give you an episode. Well, I guess, episode would be maternity care, so mom becomes pregnant, baby is coming. A bundled payment mechanism then would bundle all the services for the mother, prenatal care for the mom and the baby, delivery at the hospital. If there is an epidural, it would cover an epidural. If there is a C-section, it would make a payment for the C-section. And it would cover some level of post -- postdelivery, follow-up care. So we would bundle that nine-month episode into a single-payment allowance. Now the provider has an incentive to perform within that bundle.

REDACTED

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REDACTED

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REDACTED

Q. Is ConnectedCare a risk-based care system?
A. Yes.
Q. And did you offer ConnectedCare to St. Luke's?
A. Yes. We offered it to St. Luke's before we offered it to Saint Al's.
Q. And did they participate?
A. No. We had a -- we attempted to get them interested in it for many, many months. We were running into a filing deadline with the Department of Insurance, just in 2012. And, ultimately, St. Luke's said that they did not want to compete with Saint Al's on price. They had heard that we were going to offer a program to Saint Al's as well. So they declined to participate.
Q. Did they provide further insight into their rationale for not wanting to compete on price with Saint Alphonsus?
A. No. They didn't provide further rationale, but we did -- of course, we learned that they brought their own insurance company into the marketplace, and I think that they were -- that had been part of their strategic plan, was to pursue that avenue rather than an avenue with Blue Cross of Idaho.

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MR. GREENE: Your Honor, I'm going to turn to a different topic unless you have other questions on risk-based contracting you would like me to --
THE COURT: No. That's fine. Thank you.
BY MR. GREENE:
Q. Mr. Crouch, I would just like to have you tell me just a little bit more about the Idaho market. All of us are, essentially, laypersons in this audience, so we want to get some better sense, just an overview of this market.
Just in general terms, how do the costs of physician services compare to those in other states, to the extent you have knowledge of that?
MR. STEIN: Objection, lack of foundation.
MR. GREENE: I think I would like him to answer, and then I'll ask him the foundational question, Your Honor. I can reverse it.
Mr. Crouch --
THE COURT: The cart before the horse, but --
MR. GREENE: Let me just reverse the order.
BY MR. GREENE:
Q. Mr. Crouch, do you have any knowledge of how costs for physician services in Idaho compare to costs in other states?
A. Yes.
Q. And what is the basis for your knowledge?

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A. It's an area of high interest for us, so we keep our ear to the ground for any -- any knowledge we can gain. We hire consultants and over time have hired a variety of consultants to pursue studies for us. We have some knowledge with our own claims data of claim payments for members when they go to other states, what we're paying for services of other states. And follow the national publications. There has just been a lot of conversation around payment allowances recently.
Q. And how do payment allowances for physician services compare in Idaho versus other parts of the United States?
A. I think the first strong indication -- we had suspected for a long period of time -- well, as long as I have been in the plan -- that our payment allowances were high. We were not very sophisticated in the early 2000s around trying to measure that or confirm that. We began to get a better understanding of that when we hired a firm called Dykeman and Associates to perform pricing studies for us. So Blue plans and other plans would come together and provide deidentified claims data and would deidentify the plan. And Dykeman would then calculate how your plans' allowances compare to common allowances elsewhere. I'm not recalling the results of that study, but it was something like we were 150 percent of the common plan.

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Medicare published a -- not Medicare, rather, MedPAC, which is a consultant to Congress around issues related to the Medicare and Medicaid programs, they published a statistic in 2008 that indicated that the average commercial plan pays 120 percent of what Medicare would pay. So that gave us a very solid benchmark. We started to look at what we paid on our own and recognized that we were anywhere from, commonly, 176 percent of Medicare to well over 200 percent of Medicare. It depends on the professional service you are looking at.
We hired Milliman and Associates, which is an actuarial firm. We used their Seattle office to perform a study for us in their Seattle office. They identified -- well, they did two studies for us. One study was we asked them to perform a benchmarking study where they would compare our fees against what they would consider to be appropriate benchmarks. And in that benchmarking study, I am a little foggy on all the details, but I think it varied from 138 or -39 percent of other plans. Well, it had ranges I think to be maybe more specific. There were ranges of fee schedules. But we were always high, and it was high by double digits into the high double digits for some markets.
We have had other -- well, I just saw an article from *Health Affairs* just two days ago this month --

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MR. STEIN: Your Honor, I'm sorry. I let this go, but I think we need to have some foundation here or there's a best evidence issue. I mean, what studies are we talking about? Where are these documents so we can at least --

THE COURT: I'm not sure we need to get into the studies unless the studies themselves are presented. And I think the witness answered the question.

MR. GREENE: Yeah. It's his business to focus on prices here versus other places he is providing information, and it's well grounded, it seems to me.

THE WITNESS: So --

THE COURT: Just a moment. Can you identify the study? Is it important to your testimony to be able to refer to it?

THE WITNESS: I was deposed on it. I know the study is in the file somewhere. I can't say that I've looked at it since May.

THE COURT: Well, if you're going to refer to it, I think you need to provide counsel with a copy so that they can, at least, examine you on it if you're going to offer anything by way of that information. But this is something you would and do rely upon in your current business?

THE WITNESS: Yes. Correct.

THE COURT: I'm going to allow it, but I think you will need to provide the citation to counsel so that they

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can cross-examine. We are going to be recessing in about seven minutes, so that should be a pretty simple task.

MR. GREENE: Yes. We'll get that done by tomorrow, Your Honor, for sure.

BY MR. GREENE:

Q. So can you just give me just a basic number for, approximately, how costs for physician services compare? Is it the 176 to 200-some-odd percent that is the correct number, from your perspective?

A. Correct. The study I was mentioning just came out in the *Health Affairs* journal just this week. It happens to be their September issue. They were looking at fee schedule payments across the country for commercial health plans, and they gave a number then so we could look at that number, and we are -- I just read this --

THE COURT: "We" being Blue Cross of Idaho?

THE WITNESS: I'm sorry, yes.

THE COURT: Of Idaho?

THE WITNESS: Blue Cross of Idaho. 140 percent of the average for commercial plans in the United States.

BY MR. GREENE:

Q. Okay. And is that higher or lower than some urban states?

A. Well, so the urban states would be 100 percent then. So the reference I was giving about 140 percent is

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that was comparing us to the common fee schedule in the country for a commercial plan.

Q. Would you be higher than California?

A. Yeah, I would suppose California, Minnesota. Some of those markets are driving much of the average. So we would be quite a bit higher than California.

Q. Okay. And from your perspective, what explains this higher reimbursement situation in Idaho?

A. I don't know that there is a single explanation. It certainly has developed over time. Medical -- the marketplaces across the country developed their own little signature of utilization patterns and payment levels. It wasn't until the 1990s that a standardized payment methodology was even developed. It was very common prior to that date that commercial payers would simply pay a discount from billed charges or billed charges when they were presented with a claim.

And the Medicare developed the RBRVS system, which is a system that identifies a relative value for every procedure that can be performed, and then that allows payers, then, to establish fee schedules using those relative values. Just need to come up with one conversion factor, and say in our case it's $60. We'll take $60, multiply it times any procedure that's going to be billed to us. Because each procedure has that relative value, we know

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what the payment allowance is going to be. When that system was developed, it became very obvious that there were wide variations in payment across the country.

And in Idaho I think one of the challenges has always been that the markets composed of a series of very small sort of monopoly markets where there is a single hospital in a town, there would be one orthopedic group in a town, there would be one ear, nose, and throat specialist.

And so what we saw when we converted over from those discount-from-charges contracts to this more standardized approach is that the physician in Pocatello was charging a very different rate than the physician in Coeur d'Alene, and that was even a different rate than what a physician might charge in California. So the result of that variation is, in some large degree, a result of there wasn't a lot of competition in those markets, and physicians could, essentially, pick their number when they were trying to decide what they were going to bill.

So you compounded that with, I think, more and more aggressive negotiations over what fees would be over time, and we end up with the situation we're in currently.

Q. And with respect to those monopoly markets, do you pay those higher rates?

A. We did back in the day. Now, that would have been in the 1990s. We converted to the RBRVS system at Blue

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Cross of Idaho around the year 2000, so that was a couple of years before I arrived. When that happened, when we converted over, we couldn't convert over to a single -- when the conversion factor -- let me know if I need to get into more detail about the mechanics of the program, but that -- if we were to adopt a single conversion factor that was going to overpay some physicians relative to what they had seen in the past, it was going to underpay other physicians relative to what they had seen in the past, and we knew we'd end up with a bunch of payment increases for anybody under the average and a bunch of contract terminations for anybody over the average.

So we implemented -- have over time implemented contract terms that try to reduce the variation on that fee schedule and have been quite successful, I think, so that now, in 2013, every primary care doctor in the state is based -- has fees that are based on a single conversion factor. And specialists in the state are based -- have fees that are based around a small range of conversion factors.

Q. And this combined fee, does this take into account the monopoly situation in some of these submarkets you have described?

A. Yeah. We have -- we have struggled over time. There have been periods when the -- one year Medicare was reducing the relative values for gastroenterology services,

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as an example. We wanted to adopt that change straight from Medicare since they administer the program, that we ended up with contract terminations from a large number of gastroenterology physicians, so we had to make some accommodation that phased it in over time. Something similar happened with orthopedic surgeons a number of years ago.

So there have been periods when it's been more challenging, but we have always been able to negotiate a reasonable compromise and, I think, make appropriate progress.

Q. And do you have knowledge of how hospital service rates or rates of reimbursement for hospital services in Idaho compare to other states?

A. We do. It's an area we have --

Q. The question was do you have knowledge?

A. Oh. We have some knowledge, yes.

Q. Okay. And what's the basis for your knowledge?

A. Again, we end up using the Medicare system as a benchmark, not that Medicare payments are appropriate, but there are published data around how those benchmarks compare. So we use the comparison against what Medicare pays and we can see what we would pay for the same service and have an understanding of how much more we pay than Medicare.

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Q. And how much more, in percentage terms, do you pay than Medicare?

A. On the inpatient side -- so we, roughly, break hospital services into inpatient activities and outpatient activities. If you're admitted to the hospital overnight, then you would be considered an inpatient. And for those inpatient services, our payments are something between 150 and 200 percent of Medicare. For outpatient services, our payments are commonly 300 percent of Medicare. In some cases they can be substantially higher.

Q. And I'm very appreciative of the fact that the cost of living appears to be quite low or relatively low in Idaho. How does that get factored in to outpatient rates of 300 percent or more?

A. When we do our internal comparisons, we adjust for a typical Idaho Medicare fee schedule. Medicare does make changes based on area indexes, including wages and the cost of owning the land and building buildings and even all the way down to energy, paying for utilities.

THE COURT: Could I just inquire. The numbers that you just gave, and that you've given consistently, about the relationship between what you're paying providers and as a percentage of Medicare, that's after the adjustment, kind of a locality adjustment has been made?

THE WITNESS: Correct, yes.

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THE COURT: So it wouldn't be, for example, 300 percent of the outpatient services commonly paid on a schedule in California; it would be 300 percent of the schedule for the same service provided in California as adjusted to an Idaho cost of living standard?

THE WITNESS: That's correct.

THE COURT: All right.

Counsel, we are at 2:30. Is this -- I'll let you go for a minute or two more.

MR. GREENE: This is an appropriate breaking point, Your Honor.

THE COURT: Is this a good breaking point?

MR. GREENE: Yes.

THE COURT: Counsel, let's reconvene at 8:30. Unlike this morning, we'll try to start promptly at 8:30. If you'll be in your seats and have Mr. Crouch available and, perhaps, even on the witness stand, we will try to start promptly at that time.

MR. GREENE: Very good. Thank you, Your Honor.

THE COURT: We'll be in recess, then, until 8:30 tomorrow morning.

(Court recessed for the evening at 2:31 p.m.)

REPORTER'S CERTIFICATE

I, Tamara I. Hohenleitner, Official Court Reporter, County of Ada, State of Idaho, hereby certify:

That I am the reporter who transcribed the proceedings had in the above-entitled action in machine shorthand and thereafter the same was reduced into typewriting under my direct supervision; and

That the foregoing transcript contains a full, true, and accurate record of the proceedings had in the above and foregoing cause, which was heard at Boise, Idaho.

IN WITNESS WHEREOF, I have hereunto set my hand October 31, 2013.

-s-
Tamara I. Hohenleitner
Official Court Reporter
CSR No. 619